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Recognize, Repair, and Resolve: Understanding Ruptures within the Therapeutic Alliance

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Abstract

The therapeutic alliance, or the relationship between the therapist and patient, has been a popular research topic and is believed to play an important role in therapy, but what happens when the bond is broken and trust cannot be established? Unresolved ruptures are associated with deterioration in the alliance and may lead to poor outcome or patient dropout (Safran & Kraus, 2014). In order to recognize that a rupture has occurred, seven themed rupture markers are provided, six interventions are suggested to repair the rupture, and ten strategies are indentified to assist clinicians resolve the rupture. To evaluate the understanding of mental health practitioners, an anonymous survey was distributed. Clinicians were asked to rate the frequency of observing when rupture markers have occurred within the relationship, the utilization of interventions to repair the rupture, and strategies to resolve the rupture. It was found that a relationship was determined between years of experience of the clinician and noticing compliance on the part of the client and with years of experience and linking the event to similar relational issues in a client's life. Additionally, it was determined that the recognize stage of the rupture process was identified more frequently than the later stages of repairing and resolving the rupture according to matching responses of the quantitative and qualitative questions. Strengths of this study include a sample in which 44% of respondents indicated they had 16 years of experience or more in mental health and the use of a mixed-method design. Limitations include sample size, survey instrument, and lack of funding.

Key words: therapeutic alliance, rupture, relationship, therapeutic intervention.

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The therapeutic alliance, or the relationship between the therapist and patient, has been a popular research topic dating back to the psychodynamic work of Freud (Colli & Lingiardi, 2009) and is believed to play an important role in therapy. The therapeutic alliance has been shown to be a consistent predictor of therapy outcome as well as one of the most common factors across various therapy modalities (Aspland, Llewelyn, Hardy, et al., 2008; Colli & Lingiardi, 2009; Coutinho, Ribeiro, Sousa, & Safran, 2014). Mounting evidence is available regarding how to build upon the alliance and strengthen the relationship, increasing trust and rapport, as well as therapists' characteristics that promote stronger bonds within the working relationship, but what happens when the bond is broken and trust cannot be reestablished? In psychotherapy, the emphasis has been placed on building upon and maintaining a strong therapeutic connection. Until recently, little was known about ruptures within the therapeutic alliance and how to resolve them.

Ruptures in the therapeutic alliance refer to an impairment or fluctuation in the quality of the alliance between the therapist and client and can vary in intensity, duration, and frequency (Safran, Crocker, McMain, & Murry, 1990). Due to the unique characteristics of human behavior, it is inevitable that interpersonal events can significantly impact the course of treatment as well as the relationship between client and therapist (Safran & Kraus, 2014). Ruptures can occur as a result of therapist attachment (Marmarosh, Schmidt, Pembleton, et al., 2015), cultural variations (Gaztambide, 2012; Vasquez, 2007) disagreements about treatment course (Martin, Garske, Davis, 2000), interpersonal problems of the client (Coutinho, Ribeiro, Hill, & Safran, 2011), and client behavior by either withdrawing, avoiding, or confronting the therapist

regarding certain topics (Colli & Lingiardi, 2009). Moreover, because therapeutic alliance ruptures are trans-theoretical phenomena, the application of repairs and resolutions are relevant and significant for all mental health practitioners, regardless of orientation (Safran & Kraus, 2014).

Apart from being relevant for all mental health practitioners, understanding the role of ruptures within the therapeutic alliance is particularly important for social workers. According to a study conducted by the National Association for Social Workers (NASW) in 2006 (Whitaker, Weismiller, Clark, & Watson, 2006), social workers spend 96% of their time in direct service with clients while serving primarily in mental health roles (56% in hospital settings, 38% in private practice, and 20% in behavioral health clinics). Due to the high dispersion of social workers in roles that work directly with clients who require mental health treatment interventions, it is imperative to understand the importance and relevance of not only a strong therapeutic alliance, but also be trained and knowledgeable in repairing and resolving ruptures when they do occur. Furthermore, core principles of social work relate back to cultural components of the therapist, as well as the client, and also address potential conflict regarding power imbalances in such a relationship. Ungar (2002) disagrees in using terminology, such as alliance, because it infers that the joint relationship is egalitarian in nature and thus void of any power imbalance. Not only do social workers need to address power imbalances within the partnership with their clients, they also must consider other factors that include transference/countertransference, disagreement in values or treatment planning, cultural biases, and socioeconomic status, while considering the client from a person-in-environment perspective. A rupture in the alliance can become therapy-interfering for both the client and

therapist which can lead to an increase in drop-out rates, disagreements regarding treatment course, and can range in intensity from mild to severe infractions.

In some cases, minor infractions can go unnoticed by the therapist or even remain out of conscious awareness for the patient; in this case, the rupture may have little to no impact on the alliance itself (Safran & Muran, 1996). Unresolved ruptures are associated with deterioration in the alliance and may lead to poor outcome or patient dropout (Safran & Kraus, 2014) as well as lead to a vicious cycle of referring-out problematic patients who may never receive the help they are seeking. However, the impact and potential recourse of more severe ruptures within the therapeutic alliance can have detrimental results. Therapists may experience negative feelings regarding the rupture event, such as ambivalence or confusion, feeling guilty and incompetent, increased tension surrounding the topic, and the need to balance the risk with potential benefits of beginning a new treatment strategy (Coutinho, Ribeiro, Hill, & Safran, 2011). Likewise, clients may also experience feelings of ambivalence or confusion, in addition to feeling abandoned and helpless, criticized by the therapist, as well as feelings of desperation, anger, and anguish (Coutinho, Ribeiro, Hill, & Safran, 2011).

It is clear that the therapeutic alliance is a major focus of the therapeutic process because it can impact the outcome of therapy. It would be logical, then, to assume that based on the importance of the alliance and the effort involved in creating a strong, positive connection with the client, that it would be just as important to understand when a bond cannot be formed. Therefore, it is surprising that recognizing ruptures within the therapeutic alliance and the resulting repair and resolution process is just beginning to take stake in literature. Many sources specifically focus on various aspects of the rupture, such as the repair or identifying that a rupture has occurred. Recognizing a gap in current research provides an impetus to

understanding that problems exist regarding interpersonal factors within the therapeutic alliance. Clinicians need to understand how to recognize, repair, and resolve ruptures within the bond and connection of the clinician and client in order to maintain the efficacy of treatment. Therefore, the purpose of this study is to understand the role and process of the therapist in recognizing, repairing, and resolving ruptures within the therapeutic alliance which has been determined through the use of an electronic survey dispersed to mental health practitioners.

Literature Review

In order to better understand how ruptures occur within a therapeutic relationship, first it is relevant to understand the importance of the therapeutic alliance. The alliance, or bond formed between a client and therapist, will be explored back to its inception, potential challenges, as well as relevant cultural factors to keep in mind. From there, ruptures, or tension within the therapeutic alliance, will be further defined through how to recognize, repair, and resolve these breakdowns when they do occur within the therapeutic relationship.

Therapeutic Alliance

The Foundation. In 1912, Sigmund Freud first recognized the therapeutic contributions of transference and countertransference in psychoanalysis (Colli & Lingiardi, 2009; Elvins & Green, 2008; Martin, Garske, & Davis, 2000). However, literature indicates that further study surrounding these concepts remained dormant until 1962, when Anderson applied the label of the 'therapeutic bond' to explain the purpose of empathy and rapport in a clinical relationship; which was supported by the work of Rogers in 1965, who acknowledged the importance of therapist empathy as it relates to a client's therapeutic experience (Elvins & Green, 2008). Empirical testing began in 1975 when Orlinsky and Howard studied the credibility of the therapist and treatment engagement as strong predictors regarding the therapeutic outcome (Elvins & Green, 2008).

It was around 1975 that the concept of the therapeutic alliance began to take stake and rise in popularity. Since then, the purpose and impact of a strong therapeutic alliance has been studied as it relates to outcomes in therapy. Most argue that this alliance is the strongest predicting factor of positive outcomes, outweighing therapeutic disciplines, type of treatment,

and presenting issue (Eubanks-Carter, Muran, & Safran, 2015; Gaztambide, 2012; Marmarosh, Schmidt, Pembleton et al., 2015; Martin, Garske, & Davis, 2000; Safran, Crocker, McMain, & Murry, 1990; Safran & Muran, 1996; Safran, Muran, & Eubanks-Carter, 2011; Safran, Muran, Wallner-Samstag, & Stevens, 2001). Over time, a multitude of terms have been used to describe this concept, such as, working alliance, therapeutic bond, and helping alliance; however, the use of the term therapeutic alliance has taken precedence to define and describe three major themes: "(a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks" (Martin, Garske, & Davis, 2000, p. 438; Safran, Crocker, McMain, & Murry, 1990).

Challenges. Although the bond formed within the therapeutic alliance between a therapist and a client has shown to be a strong predictor of positive outcomes in therapy, it is not without challenges. Due to the unpredictable nature of human behavior, the alliance itself cannot be considered a rigid concept that remains unchanged once it has been established (Colli & Lingiardi, 2009). The alliance is a relational aspect of therapy and treatment intervention that not only fluctuates over time but must adapt to a variety of situations (Binder, Holgersen, & Nielsen, 2008). Factors that can impact the alliance include the quality of the alliance and when it is established throughout treatment (Binder, Holgersen, & Nielsen, 2008), the age of the client (Binder, Holgersen, & Nielsen, 2008), clients with psychiatric disabilities (Bressi Nath, Alexander, & Solomon, 2012), the efficacy of treatment (Colli & Lingiardi, 2009), and complex mental health interventions (Elvins & Green, 2008) to name a few. Furthermore, each theoretical framework that is used to guide treatment interventions views the therapeutic alliance in varying levels of importance in addition to how the alliance is applied. Psychoanalysis views the alliance "as key aspects of process and change" (Elvins & Green, 2008, p. 1168), Experiential Therapy

relies heavily on the bond, viewed as a partnership, where the client is an expert in their experience and the therapist is an expert in facilitating exploration (Watson & Greenberg, 2000), and Cognitive Behavioral Therapy (CBT) pairs the alliance with the competence of the therapist (Aspland, Llewelyn, Hardy, et.al., 2008), again, to name a few.

There is one treatment modality in which ruptures do not have a similar meaning as other methods, in fact, the concept of ruptures within the therapeutic context do not exist. In Dialectical Behavior Therapy (DBT), rupture events are tied into a larger theme regarding therapy-interfering behaviors. Therapy-interfering behaviors refer to any behavior that interrupts or impacts the ongoing treatment and can be caused by the client, therapist, or both parties in therapy (Linehan, 2014). These behaviors are conceptualized on a deeper level by targeting the impasse with a goal of attaining a better understanding of why it occurs and how it plays a role in other aspects of the clients' life. As a result, a rupture within the therapeutic alliance is not considered an isolated event, instead, a rupture is evaluated on a greater scale to determine what maladaptive behaviors and thought processes are interfering within the therapeutic relationship and what correlations can be made to the clients' personal life. Perhaps moreso than other treatment modalities, DBT therapists may experience an increased amount of ruptures due to the complex nature of their clients symptomology as DBT was designed for persons diagnosed with Borderline Personality Disorder, those with high suicidality or self-harming behaviors, and also those with co-morbid diagnoses (Linehan, 2014).

Cultural Impact. Psychotherapy has shown to be effective for 75% of clients who present from a range of symptomology, background, and demographic, yet there is one population that may not be receiving the treatment they need due to underutilization of psychotherapy services in addition to increased drop-out rates (Vasquez, 2007). Ethnic minority populations may face

additional challenges when seeking mental health treatment due to conflicts related to culture and preferences in therapy. These cultural differences may present in the form of microaggressions, which are the "verbal and non-verbal communications, intentional and unintentional, that portray insensitivity, disrespect, and/or negligent attention to come salient aspect of the others' cultural heritage" (Owen, Imel, Tao, Wampold, Smith, et al., 2011, p. 204). Within the confines of the therapeutic relationship, microaggressions are more likely to be seen in regards to treatment interventions that do not align with the clients' cultural beliefs or values as well as the idealization of one's own cultural group (Owen, Imel, Tao, et al., 2011). Understanding microaggressions as they relate to the therapeutic alliance is a major component to building a therapeutic relationship with a client whose culture may differ from that of the therapist or be held to a higher regard.

More recently, literature has begun to address the impact of cultural differences within the therapeutic dyad; components regarding gender, race, and sexual orientation are being researched in order to determine the impact on the therapeutic alliance. Gender can serve a major role in therapy in addition to building upon the therapeutic alliance due to the preferences of the client. Often, clients may be more comfortable to work with a therapist of the same gender, but can eventually become equally comfortable with a therapist of another gender after additional work has been completed to ensure a safe and comfortable space (Gehart & Lyle, 2004). Some settings go so far as to match a client with a therapist, either based on the gender of both the client and therapist or on the preferences of the client, in order to enhance the relationship before therapy even begins (Bhati, 2014). Men, in particular, are less likely to access mental health services, so male clients may benefit from seeking treatment from a same-gender clinician (Richards & Bedi, 2014). In a study done by Gelso and Mohr (2001), it was

found that the subsequent bond formed between a therapist and client who share similar racial or sexual identities helped promote the therapeutic alliance, however for those dyads who differed in race or sexual orientation, the process to form the initial bond was more difficult and complex and can be based on either a perceived or actual difference.

Ruptures within the Therapeutic Alliance

Ruptures within the therapeutic relationship can be caused from a range of phenomena and can include components related to tension in the relationship, breakdowns or strains, transference or countertransference issues, empathic failures, or misunderstandings (Safran & Kraus, 2014). For the purpose of this study, a rupture within the therapeutic alliance refers to "an impairment or fluctuation in the quality of the alliance between the therapist and client" which can also vary in intensity, duration, and frequency (Safran, Crocker, McMain, et al., 1990, p. 154).

Recognizing Ruptures. In order to determine if a rupture has occurred within the therapeutic relationship, it can be beneficial to understand different types of ruptures. Two major types of ruptures have been identified, namely ruptures of withdrawal or confrontation. A withdrawal marker is one in which the client withdraws or avoids the therapist, their own emotions, or treatment in order to maintain the relationship, whereas a confrontation rupture refers to situations where the client expresses their dissatisfaction verbally, in a hostile manner, in an attempt to control the therapist or situation (Safran, Muran, Samstag, et al., 2001; Coutinho, Ribeiro, Sousa, et al., 2014). Furthermore, Safran, Crocker, McMain, and Murray (1990, p. 157-159), have utilized these broad types of ruptures and further classified ruptures more specifically as seven themed *markers*:

1. *Overt expression of negative sentiments*: This theme is identified when the client overtly expresses negative feedback towards the therapist through means of accusations, attacks, or ill-will.

2. *Indirect communication of negative sentiments or hostility*: Similar to the previous theme, clients expressing this type of rupture marker will also show negative sentiments towards the therapist, however here, the negativity is more indirect through sarcasm, nonverbal cues, or passive-aggressive behavior.

3. *Disagreement about the goals or tasks of therapy*: This marker involves the client questioning, disagreeing, or rejecting the treatment intervention employed by the therapist.

4. *Compliance*: Here, in an effort to keep the peace with the therapist, the client gives in and relents to various aspects of treatment even though they did not indicate any interest in certain therapeutic activities.

5. *Avoidance maneuvers*: Further expanding on withdrawal type ruptures, clients may also avoid interventions presented by the therapist by changing topics, refusing to explore topics at greater depth, or may completely ignore the therapist.

6. *Self-esteem-enhancing operations*: A client may attempt to provide explanations for their behavior as a means of defending their situation.

7. *Nonresponsiveness to intervention*: Finally, this marker relates to when clients do not positively respond to intervention or utilize the treatment strategy being used.

Scales. In addition to being aware of behavior changes in the client to determine if a rupture has occurred, there is also a multitude of scales available to assist the therapist in

addressing rupture markers. Elvins and Green (2008) compiled an exhaustive list of scales (63 to be exact) that are used to define characteristics of the therapeutic alliance and identify if ruptures have occurred. Their comparison extrapolates a wide variety of scales and defines them through the date developed, the concept or background applied in the scale, as well as a description of what the measure includes. Although this list is extensive, it does not provide further information regarding the reliability and validity of the scales explored. Additional research may be required to determine if these scales would provide significant results. In an effort to provide one example for the purpose of this study, a rupture would be identified if a client decreases one point or more on the Working Alliance Inventory (WAI) as noted by Coutinho, Riberiro, Sousa, and Safran (2014). Although there are a variety of tools available to measure the strength of the alliance and assist in determining if a rupture has taken place, even the most skilled clinicians can experience difficulty recognizing ruptures, let alone attempting to repair them (Safran, Muran, Samstag, et al., 2001).

Repairing Ruptures. Once the alliance rupture has been recognized, it is primarily the role of the clinician to take action in order to repair the bond or imbalance within the therapeutic relationship. Safran, Muran, Samstag, and Stevens (2001) propose a few strategies to begin to alleviate the tension caused by the rupture: the therapist must respond to the client in a nondefensive manner, adjust their own behavior to make accommodations for the relationship, promptly identify when tension or stressors arise within the dyad, and continuously make efforts to build and maintain the rapport and trust with the client. In addition to these relational strategies, six interventions are suggested in order to repair the rupture within the therapeutic relationship (Safran, Muran, & Eubanks-Carter, 2011, p. 81-82):

1. *Repeating the therapeutic rationale*: Often, treatment planning occurs at the onset of therapy and although the strategy is typically outlined for the client, it is understandable that the goals of therapy can be forgotten or overlooked over time if not frequently reviewed. As a means of repairing a rupture, it may be beneficial for the therapist to review the treatment plan and goals in order to determine if the client understands the processes involved, the expectations set forth, as well as the ability to acknowledge the progress made thus far.

2. *Changing task or goals*: Once the rationale has been reviewed, it may be necessary to modify the goals or strategies used. If there are disagreements regarding the course of therapy, the clinician may need to modify the techniques used to make the intervention more accessible and meaningful for the client.

3. *Clarifying misunderstandings at a surface level*: Repairing a rupture does not need to be a complex event. Often, it can simply be recognizing when a client's demeanor changes in session by addressing any confusion or maladaptive thought processes that the client is experiencing. This response may also reduce the likelihood of a more severe rupture occurring within the relationship.

4. *Exploring relational themes associated with the rupture*: Once misunderstandings are addressed at the surface level, underlying relational themes to the rupture may be identified; such as, clients experiencing difficulty working with a therapist of a specific gender, therapists in general, or authority figures, to name a few. These themes may provide further insight into the challenges faced by the client which can then be applied to the treatment plan and goals for therapy.

5. *Linking the alliance rupture to common patterns in a patient's life*: Sometimes it may be beneficial to address ruptures by creating a link between what is experienced during session and how that is mirrored in the client's life. Once these patterns are identified, they can be further explored in the safe environment of therapy, which would not only address the rupture that has occurred but provide the basis for ongoing treatment interventions.

6. *New relational experience*: The strategies used in therapy may not always be fully addressed and known to the client. The therapist may hypothesize relevant strategies, often without knowledge of the underlying themes or meaning to client, and use these methods as a way of offering the client a new relational experience. Some examples may include when the therapist takes a more assertive stance in session, asks more questions, or provides more feedback. This technique may open the door to using other strategies listed above to not only repair a rupture but expand on the therapeutic relationship.

Resolving Ruptures. The process of recognizing and repairing a rupture when it occurs can be beneficial to the therapeutic relationship and the outcome of therapy. Although a rupture event is often identified as a negative aspect of therapy, the resolution of disagreements or tension within the dyad can build upon the alliance, therefore increasing the bond which could also provide insight into a client's thought process, and could lead to a therapeutic breakthrough (Aspland, Llewelyn, Hardy, et al., 2008). The resolution of ruptures can also utilize strategies employed by the therapist in an effort to prevent future ruptures from occurring, which can increase the therapeutic alliance by tending to factors within the relationship that could potentially lead to ruptures. The experience of a rupture can also improve communication in a safe environment. The resolution of a rupture can encourage the therapist and client to further explore metacommunication deficits through a lens of curiosity instead of hostility or blaming

(Eubanks-Carter, Muran, & Safran, 2015). Safran and Kraus (2014, p. 383) have provided ten strategies to assist clinicians resolve disagreements that involve metacommunication:

1. *Explore with skillful tentativeness and emphasize one's own subjectivity*: Therapists should strive to explore any relational deficits in a curious fashion in order to invite and engage with the client through the therapeutic process.

2. *Do not assume a parallel with other relationships*: Although circumstances may be duplicated or mirrored in other relationships, it is important to not jump to this assumption and view the rupture as an independent event.

3. *Accept responsibility*: The therapist must become self-aware of how they contribute to the therapeutic relationship and take responsibility for contributions when necessary. The therapist should maintain an open and nondefensive stance when addressing contributions to the dyad.

4. *Start where you are*: Treat each session independently; what transpired in the previous session may not carry over to the next. Be present in each moment to be aware of feelings that may arise and address them with the client as they occur.

5. *Focus on the concrete and specific*: Therapists should not rely on generalizations, but instead, questions, observations, and comments should focus on specific events or examples for the client.

6. *Evaluate and explore patients' responses to interventions*: The therapist should monitor the level to which a client seems involved or engaged in their treatment intervention. If

a client becomes despondent or withdraws, the intervention should be evaluated to determine if it truly is the best fit for the client.

7. *Clarify or reflect on the relational meaning of the therapist's intervention for both the patient and therapist*: Treatment modalities can vary in effectiveness for both the client and therapist. Therapists should evaluate interventions for unique complexities that may be related back to themselves or the client.

8. *Establish a sense of collaboration and we-ness*: Therapists should validate the concerns and feelings of the client during the rupture and emphasize that the event happened to the relationship as a whole and is therefore a shared dilemma.

9. *Judiciously disclose and explore your own experience*: When appropriate, the therapist should share feelings they experience as they relate to the rupture. Being truthful, open, and honest regarding a rupture can invite the client to share their experience in order to work together towards resolution.

10. *Expect resolution attempts to lead to more ruptures, and expect to revisit ruptures*: The exploration of a rupture event can trigger another impasse, so therapists should be prepared for this and acknowledge it as part of the resolution process while tensions are worked out.

Clinician Impact. It is understandable that a rupture event can weigh heavily on the therapist. Therapists may be more likely to feel "frustrated, disappointed, angry, hurt, confused, and have low self-efficacy" following a rupture with their client which caused them to reflect and doubt their own abilities (Coutinho, Riberiro, Hill, et al., 2011, p. 526). Furthermore, therapists may not know what to do in the moment of a rupture, feel ambivalent, guilty, or

incompetent, recognize the difficulty of the situation, and become hesitant to try new interventions because it may be too risky (Coutinho, Ribeiro, Hill, et al., 2011).

Gap in Literature

It is evident from literature how important the therapeutic alliance is on the outcome of therapy. Understanding the importance of relational factors and its impact on the alliance, it would be assumed that understanding ruptures within such a partnership would also be considered a significant factor in therapy. This is not the case in current literature, as searched through the University of St. Thomas library database, Summon; a variety of keywords were used to search the literature, such as therapeutic alliance, therapeutic ruptures, working alliance, resolution of ruptures, and ruptures and culture. As noted above, there are a variety of scales and measures that can be used to determine if a rupture has occurred, but minimal data exists that focus on the resolution and repair of a rupture within the therapeutic alliance. In addition, the majority of literature available has been primarily studied by a small group of professionals, often headed by one Jeremy D. Safran who has spent a career researching alliance ruptures. Due to the unpredictable nature of working with a demographic of clientele who may experience a range of mental illness or disorder, tensions within the relationship are more likely to occur. Therefore, understanding not only how to recognize ruptures within the therapeutic alliance, but also how to repair and resolve these events when they do occur is of significant importance and additional research should be done to evaluate these factors as they relate to therapeutic outcomes.

Summary

Although there are major deficits in research regarding ruptures within the therapeutic alliance, it is clear that these events can have a major impact on therapy. Specifically for clinicians, ruptures can induce self-doubt, anxiety, and lack of confidence in treatment intervention. To this end, it is helpful to have a list of strategies available on how to resolve, repair, and recognize ruptures when they do occur. It is relevant to understand how cultural factors can impact the therapeutic alliance, such as differences in gender, sexual identity, or cultural heritage. Finally, understanding the foundation of the therapeutic alliance over time allows clinicians the opportunity to practice the most empirically-supported method to support the relationship. With this information in mind, it begs the question, what is the role and process of the therapist in recognizing, repairing, and resolving ruptures within the therapeutic alliance?

Conceptual Framework

Ruptures within the therapeutic alliance can be better understood when researched through a specific lens, here, through the lens of the *Ecological Perspective*. The *Ecological Perspective* provides further explanation regarding how individuals interact with their surrounding environment by progressively making accommodations throughout the lifespan, in addition to the interplay provided by the environment (Forte, 2007). Within the *Ecological Perspective*, several methods can be applied to the therapeutic alliance and the resulting rupture that can occur. The application of this perspective can be applied multisystemically by evaluating micro-systems, meso-systems, and macro-systems, although for the purposes of this study, the focus will primarily be on the micro-system of the client/therapist pair. The meso-system reflects the additional systems involved that extend to the supervision of the therapist as well as additional pressure set forth from the administration of the agency to which the therapist is involved. The macro-system references any societal implications, such as stigma, that could impact the occurrence of ruptures and the resulting repair and resolution. Specifically, by applying *Systems Theory* and *Oppression Theory*, identifying key concepts within the theory as they relate to ruptures, and determining how the Ecological Paradigm can provide guidelines for treatment within a clinical setting, it will be shown how ruptures within the therapeutic alliance can be understood through the lens of the *Ecological Perspective*.

Systems Theory, as a component of the *Ecological Perspective*, offers explanations as it relates to the bond created by the therapeutic alliance between a therapist and a client, and also provides insight into why ruptures can occur and how that impacts the system as a whole. Specifically speaking, the whole is greater than the sum of its parts (Forte, 2007). This means that the therapeutic alliance in itself is a system which can provide healing and repair for the

therapist and the client, when the bond is formed and maintained. Within this theory, there is an inference for the system to preserve a homeostatic balance in an effort to remain unchanged, therefore, the environment (the alliance) searches for ways to repair and resolve any ruptures that do arise (Forte, 2007). Furthermore, there are two components that provide the system options into finding that balance. The first component allows for flexibility in intervention as it is applied to both the individual and the environment (Forte, 2007). Using this component, it is simple to conceptualize that human behavior must be flexible in nature as each person is made up of a unique set of morals, values, and beliefs that must be flexible in order to work together as a cohesive unit. Secondly, equifinality refers to the existence of multiple solutions to solve a single problem (Forte, 2007). In this case, there are more opportunities to return to a homeostatic balance by evaluating transference/countertransference between the client and the therapist, identifying outside factors that could impact the relationship, or differing opinions regarding the course of treatment, as some examples.

Oppression Theory, as a component of the *Ecological Perspective*, provides insight into such ruptures as it relates to a power imbalance that exists within the therapeutic alliance (Forte, 2007). Although challenging (or near impossible), social workers in particular strive to maintain an equal power balance when working with clients, but, the inherent nature of such partnership requires one to have more power than the other (in this case, the knowledge of mental health where one seeks guidance from another). Within *Oppression Theory*, two components explain power differentials within dyadic partnerships (micro-systemically). First, primary level oppression refers to the presence of an oppressor in which there is the presence of a threat, there is differential access to resources, and the oppressor has the power to objectify (Forte, 2007). Second, aptly named secondary level oppression refers to situations where the oppressor is not

physically present but continues to be internalized by the oppressed and where the oppressed takes on the behavior of oppressor (Forte, 2007). Within a therapeutic partnership, both the therapist and the client assume both roles, as the oppressor and the oppressed. *Oppression Theory* can relate back to transference or countertransference issues and power imbalances become more apparent.

The *Ecological Perspective*, as the base methodology when determining a treatment intervention, provides seven guidelines to assist clinicians in determining how to proceed with therapy. First, the person and the environment must be viewed as inseparable (Forte, 2007). With such interconnectedness between the both systems, one cannot exist without the other. Second, both therapist and client must be an equal partner in the helping process (Forte, 2007). Treatment strategies will serve no purpose if one partner is unwilling. Third, the person and the environment must be evaluated on multiple levels, ranging from micro, meso, to macro that could impact a client's adaptability (Forte, 2007). This means that if a rupture occurs, it would be important to recognize outside factors that could affect the working relationship, such as, familial worries, financial concerns, or even cultural incidents. Fourth, any areas that induce high stress levels need to be examined and not overlooked (Forte, 2007). Fifth, as a practitioner, the goal should be to continuously attempt to enhance or promote a client's personal competence through positive experiences, thus further establishing a bond within the relationship (Forte, 2007). Sixth, treatment interventions need to be formulated with the client in mind by using a goodness-of-fit strategy to ensure it is reasonable for the client and their situation (Forte, 2007). Cookie-cutter solutions may not be effective for everyone, nor would they apply to the unique characteristics of each client. Lastly, seventh, all solutions should be agreed upon within the partnership and should be maintained through mutual decision making (Forte, 2007).

Finally, it is important to mention the Ecological Paradigm that acknowledges the pros and cons of such perspective and the reality that a perfect fit between theory and application may not exist. As previously mentioned, the *Ecological Perspective* offers many strengths when using this modality to guide treatment. There are multiple points available for intervening with a client when a rupture does occur, thus increasing the likelihood that the flux of the relationship can be recognized, repaired, and resolved. Along the same lines, this perspective also allows for the inclusion of the environment and its effect on the client, the therapist, or the combined pair (Forte, 2007). Finally, through means of *Oppression Theory*, social injustices can be addressed (Forte, 2007).

There are also some limitations to the use of this perspective as it relates to ruptures within the therapeutic alliance. Although these theories allow for flexibility within the systems and multiple points at which to intervene, it does not provide any guidelines as to where to intervene first (Forte, 2007). This can be a complication because there is no hierarchy of needs that should be addressed first in order to reduce the impact of the rupture and how to resolve more effectively. Also, if resources are limited, the opportunities to intervene on multiple levels may be reduced, which could be a determining factor on whether the rupture can be properly identified and repaired (Forte, 2007). Finally, the dualistic nature of the *Ecological Perspective* runs counter to the dichotomous thinking in our social environment (Forte, 2007). In order to utilize this methodology, social constructs must be challenged to include more equal working relationships instead of allowing the norm of power balances within society to affect the system.

In summary, not only does this conceptual framework provide a guiding lens for which to view the therapeutic alliance and the resulting ruptures therein, the *Ecological Perspective* sets the tone for the research as a whole, and more specifically the instrument, an anonymous survey.

The *Ecological Perspective* has assisted in the generation of survey questions, which are also backed by the themes identified in the literature review. The theories discussed above provide a rationale for role and purpose of maintaining a strong therapeutic bond and also offer justification for the occurrence of the resulting ruptures that take place.

Methodology

Research Design

In order to investigate the recognition, repair, and resolution of ruptures within the therapeutic alliance, an online survey, available through Qualtrics, was administered to mental health professionals utilizing a convenience sample with integrated snowball sampling. The survey, as seen in Appendix A, utilizes a mixed-method design in which the majority of questions are quantitative in nature with one qualitative question at the end. By using a mixed-method design, the benefits of both quantitative and qualitative data can be applied. For example, quantitative data collection can be more efficient to gather as well as to complete by the subject, it can be more concrete in nature as their response options are provided, and tools such as charts or graphs can be used to illustrate the data. Yet, with the additive use of a qualitative question, responses can be elaborated upon and subjects can provide personal examples to give the researcher and reader a better understanding of the experience and allow further identification of themes within the subject matter.

Sample

In order to locate potential participants for the study, a combination of methods were used. The majority of subjects was identified through the use of a listserv that has already classified members as mental health professionals. Once participants complete the online anonymous survey, they had the option to use a snowball sampling method by forwarding the original email request to other professionals in their network that may also meet the criteria to participate in the study. The use of snowball sampling is an optional component for respondents

and was used as another method in attempt to ensure that enough data are gathered to allow for significant, valid, and reliable results.

In an effort to gather comparable data across subjects, it was deemed necessary to limit the sample to mental health professionals with at least two years clinical experience post-degree. By placing controls on the experience level of the respondents, it is more likely that these professionals are trained as clinical practitioners who also use these skills in direct practice. However, no controls were placed upon the type of mental health practitioner that could participate in the study, for several reasons. First, mental health professionals can range from social workers, counselors, to psychologists (to name a few), in which all types can experience the resulting bond of the therapeutic alliance and the potential for ruptures to occur. Second, the maintenance of the bond between therapist and client permeates therapeutic intervention, modality, and orientation. Although rooted within psychoanalysis and the early work of Sigmund Freud (Colli & Lingiardi, 2009), current research indicates the importance of the therapeutic alliance and its resulting outcome on therapy across nearly all forms of treatment; the exception being the level of importance to which each modality places such a relationship. Finally, for the purposes of research, placing more controls and exemptions on the respondents in the study could potentially impact the amount of data required to complete data analysis that is both valid and reliable.

Protection of Human Subjects

In order to protect the confidentiality of human subjects participating in the anonymous survey, no personal identifying information was gathered through the study apart from basic demographic information which is optional to complete (see Appendix A). The link for the online survey was sent via email to potential respondents that were identified via convenience

sampling utilizing a listserv. Once participants complete the survey, snowball sampling methods (forwarding the original email with a link to the survey) was used to gather additional respondents from similar networks thus minimizing the ability to track who has received the prompting email or who has completed the survey. Another method of maintaining confidentiality for subjects was the use of an embedded consent within the online survey. Instead of having subjects complete a formal consent form in which their personal identifying information would be known, they read a brief statement regarding the purpose and intent of the survey, and agreed by selecting an option within the survey. If the respondent agreed to the parameters of the research and responds appropriately in the survey, they were directed to complete the survey. If the respondent disagrees, they were redirected and not allowed to take the survey. Additionally, the proposal for research was reviewed by the Institution Review Board (IRB) of St. Catherine's University.

Instrument

The survey was created using Qualtrics, which is an online tool used to build surveys, questionnaires, and evaluations. Through the use of this free software, the survey consisted primarily of questions that are multiple-choice in format where the respondent needed to select the most appropriate response per their experience. The multiple-choice questions are answered using a Likert Scale, where respondents may choose from a range of Very Important to Never Important or Frequently to Never.

The survey consists of three major themes, namely questions regarding the therapeutic alliance, ruptures within the therapeutic alliance, and information regarding the demographics of the respondents. The first section, Therapeutic Alliance, consists of one multiple-choice question. The second section, Ruptures within the Therapeutic Alliance, consists of four

subsections: Recognizing Ruptures, Repairing Ruptures, Resolving Ruptures, and Therapist Experience of Ruptures. The subsection, Recognizing Ruptures, consists of one themed question that has seven areas to respond that are quantitative and multiple-choice. The subsection, Repairing Ruptures, consists of one themed question that has six areas to respond that are quantitative and multiple-choice. The subsection, Resolving Ruptures, consists of one themed question that has 10 areas to respond that are quantitative and multiple-choice. The subsection, Therapist Experience of Ruptures, consists of one open-ended qualitative question. Finally, the section, Demographics, consists of six multiple-choice questions that are optional to complete. The demographics will allow the opportunity to gather information regarding age, gender, educational degree, practice degree or license, practice area, and therapeutic modality. In sum, the survey consists of 58 questions total.

The survey questions were created with the assistance of the research committee, in conjunction with key concepts identified within the literature review and conceptual framework, specifically utilizing questions adapted from the following studies: Colli (2009), Coutinho (2011), Eubanks-Carter, Muran, and Safran (2015), Safran, Crocker, McMain, and Murray (1990), Safran, Muran, Eubanks-Carter (2011), . The survey was estimated to take respondents approximately 20 minutes to complete.

Data Collection

The data were gathered utilizing the following steps. First, respondents were sought through the use of listserv that includes mental health professionals. The following listservs were contacted for permission to contact potential respondents: Minnesota Board of Social Work, Dialectical Behavior Therapy (DBT), Board of Psychology, Board of Behavioral Psychology, and the National Association of Social Workers (NASW). The initial batch, or

group of potential subjects, were identified and contacted through membership of the listserv. A letter of permission was distributed to any department, agency, or affiliated party in which lists of members were requested to participate in this study. Upon completion of the survey, participants were encouraged to forward the initial email that includes a link to the survey to professionals from their network that may also be potential research subjects. This is optional and not required to participate in the study. Ideally, by using this method, the subjects were able to locate potential subjects as part of the survey and may also select subjects from a similar demographic or background that supports the requirements for the survey. In order to make sure enough respondents complete the survey, approximately 250 potential subjects will be contacted through the use of the listservs listed above and the use of snowball sampling when subjects forward the initial email to others. For the purposes of data analysis, the goal for this study is to have 100 subjects participate in the research.

Data Analysis

The quantitative raw data gathered through Qualtrics were analyzed using SPSS, a program designed for the manipulation and evaluation of research data. Through the use of descriptive analysis, the quantitative data were measured through frequency distributions which would provide information on count, percent, and cumulative percent of the data gathered, measures of central tendency and dispersion which provide information on the distribution of responses, as well as inferential statistics which would identify the relationship between variables by using chi-square, correlation, and t-tests (Monette, Sullivan, DeGong, & Hilton, 2001). The qualitative responses from the open-ended question on the survey were evaluated for over-arching themes and compared across respondents (Monette, Sullivan, DeGong, & Hilton,

2001). The themes were identified by addressing commonalities in language or situation, and coded as themes or subthemes as it relates to the survey question.

Bias

A potential bias that may occur is the possible impact of the researcher's personal experience on the creation of the survey questions. It is likely that the situations that arose through interactions with clients, other clinicians, as well as friendships could create a bias that may gear subjects to answer questions in a certain way. This bias could be viewed in both a positive and negative light. On the positive side, the personal experience of the researcher as it relates to building a strong alliance with a client and any ruptures that have occurred within therapy, could increase the researcher's sensitivity and allow for the creation of more expansive questions to better understand the process and concept of ruptures within the alliance. On the other hand, this personal bias could also result in survey questions that are leading respondents to answer in a certain manner, thus skewing the data and not allowing for results that are valid and reliable. In order to address the potential bias that may occur, the research committee reviewed the survey to determine if the questions were worded in a neutral manner, and were also stated appropriately for the subjects participating in the study.

The purpose of this study is to gather more information regarding the experiences of mental health professionals as they relate to the recognition, repair, and resolution of therapeutic ruptures. As a result, the intention of this research is to begin a more thorough discussion of what happens when therapeutic interventions go awry and how therapists can be more skillful and effective in managing these occurrences.

Results

The goal of this research is to obtain a better understanding for how therapists view ruptures within the therapeutic alliance, and due to the preliminary nature of this study, the analysis was purposefully done simplistically. The survey was distributed via membership of two mental health listservs, the Dialectical Behavior Therapy (DBT) listserv and the Minnesota Society for Clinical Social Work listserv. The DBT listserv is international and has an approximate total of 1,000 members across the world, whereas the Minnesota Society for Clinical Social Work listserv is local and has approximately 150 members within the state of Minnesota. Although over 100 surveys were started, only 48 were completed in its entirety. Due to the high amount of incomplete surveys, each survey question has a varying response rate. For the purposes of this study, only statistical analyses with significant results will be reported. The 61 qualitative responses for the open-ended question of the survey were coded utilizing three themes, Recognizing Ruptures, Repairing Ruptures, and Resolving Ruptures. The theme Recognizing Ruptures has been defined as the determination of if a rupture has occurred within the relationship, Repairing Ruptures has been defined as the action taken to repair the bond or imbalance within the therapeutic relationship, and Resolving Ruptures has been defined as the efforts utilized that may prevent a future rupture from occurring and tending to relational matters to increase the therapeutic relationship.

Demographics

As evidenced by Figure 1 in Appendix B (n = 69), 62 respondents identified their gender as *Female* and seven respondents identified their gender as *Male*; zero respondents identified as *Other* in reference to their gender.

Figure 1. Respondent Gender (n = 69)

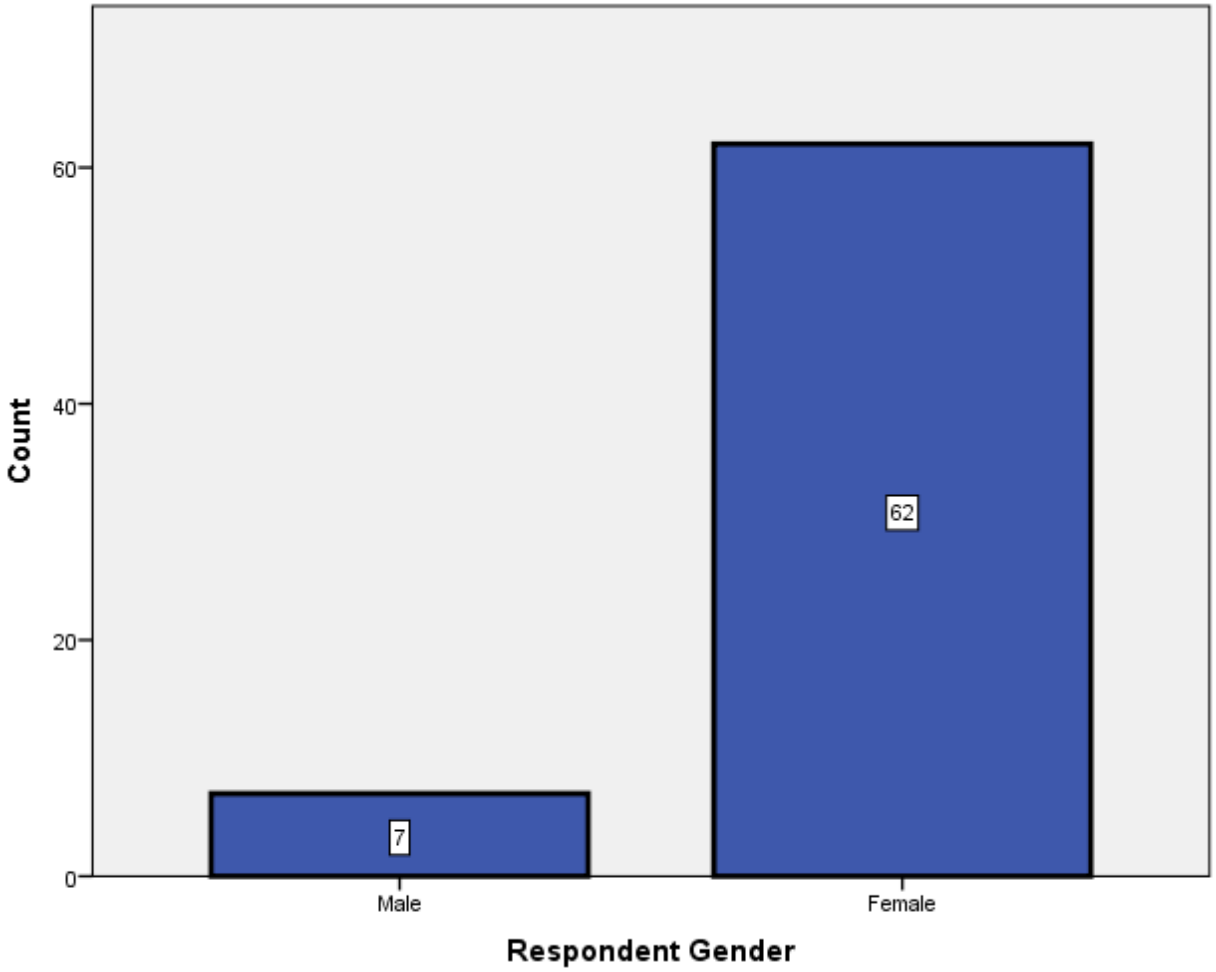


Figure 2 (Appendix B, n = 70), represents the range of ages of the respondents; four respondents attested to being within the age range of *26-30*, 14 respondents were *31-35*, seven were ages *36-40*, ten respondents were *41-45* in age, 11 were *46-50*, seven were *51-55*, nine were ages *56-60*, and finally, eight respondents identified as being within the *60 years old or greater* category.

Figure 2. Respondent Age (n = 70)

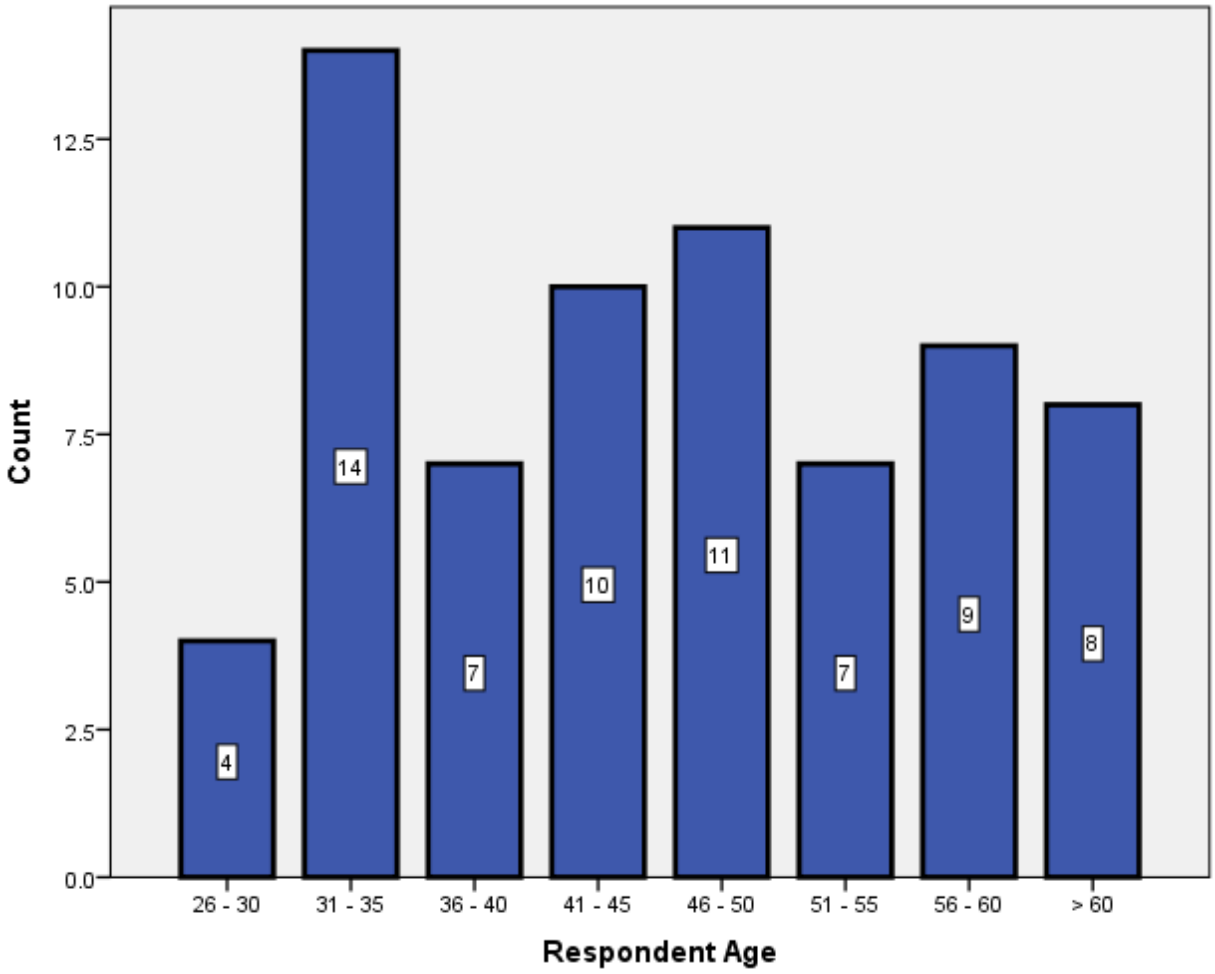
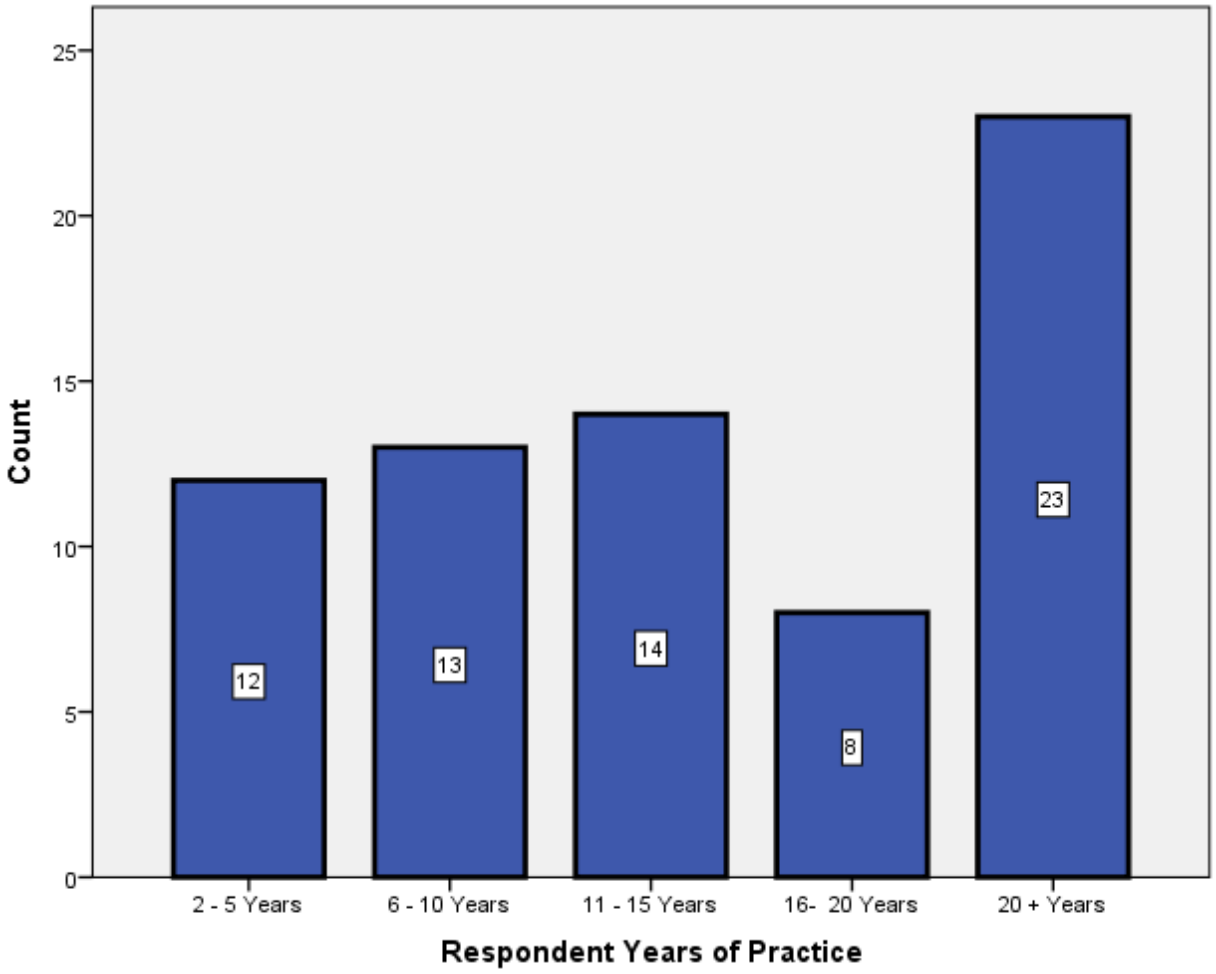


Figure 3 (Appendix B, n = 70) represents respondent's years of clinical practice; 12 indicated they have been practicing for *2-5 years*, 13 for *6-10 years*, 14 have been practicing for *11-15 years*, eight *16-20 years*, and finally 23 respondents have been practicing over *20 years*.

Figure 3. Respondent Years of Practice (n = 70)



Due to the amount of variance in respondents' licensure classifications, no pictorial representation is depicted; however the majority of respondents identified as being licensed as a social worker, counselor, or psychologist and used the *Other* category to provide distinctions based on their municipality or state (the survey provided options based on the title as classified in the state of Minnesota). Specifically, two respondents indicated they practice as a Licensed Social Worker (LSW), two respondents practice as a Licensed Graduate Social Worker (LGSW), one practices as a Licensed Independent Social Worker (LISW), 18 practice as a Licensed Independent Clinical Social Worker (LICSW), four practice as a Licensed Psychologist (LP),

three practice as a Licensed Marriage and Family Therapist (LMFT), four practice as a Licensed Professional Counselor (LPC), four respondents practice as a Licensed Professional Clinical Counselor (LPCC), zero respondents practice as a Licensed Independent Drug Counselor (LIDC), zero practice as a Tribal Mental Health Practitioner, 26 respondents answered *Other*, and two respondents answered *None*. For those that answered *Other*, some respondents entered their field of practice as a Psychologist, Clinical Psychologist, Licensed Clinical Social Worker (in the states of Colorado and New Jersey), LCSW-BACS, Licensed Associate Professional Counselor (LAPC), LMHC, Nurse Practitioner, LMSW (in the state of New York), Licensed Mental Health Professional (LMHC), Registered Psychotherapist (in Ontario, Canada), Psychologist (PhD), Clinical Psychologist (in New Zealand), Registered Clinical Psychologist (in New Zealand), Doctor of Psychology (Psy. D.), Registered Social Worker (in Canada), and Addictions Counselor. Finally, although respondent location was not formally asked in the survey, some respondents shared their location; apart from Minnesota, some respondents indicated they were from New Jersey, New York, Canada, and most surprising, New Zealand. Due to the anonymous nature of the survey, it is unknown how many participants responded from each location.

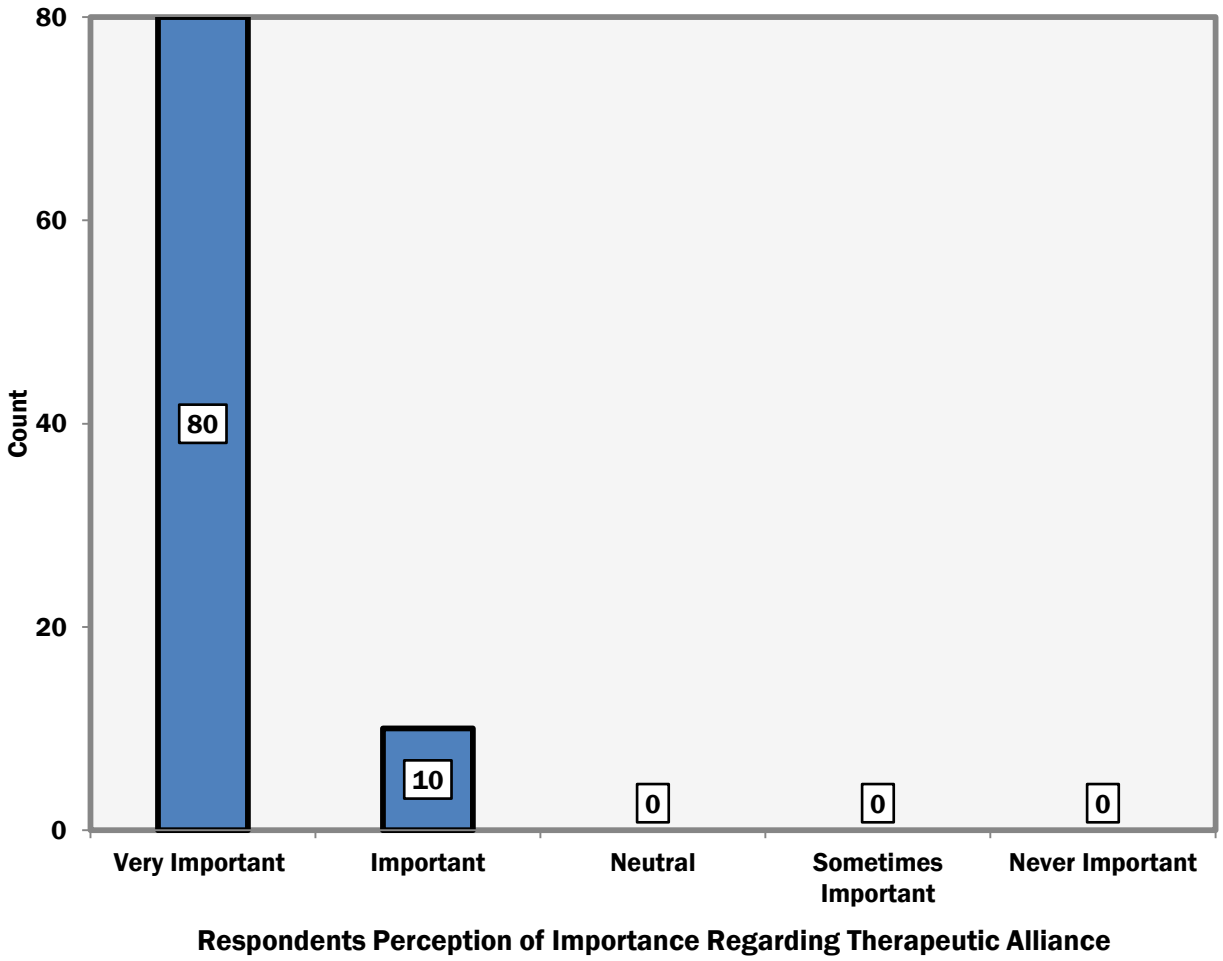
Respondents were also asked which treatment modalities they utilize in practice and were given the option to select multiple forms of treatment. Within this sample, the two most selected treatment strategies were *Cognitive Behavioral Therapy (CBT)* which had 57 total responses and *Dialectical Behavior Therapy (DBT)* which had 52 total responses. *Solution-Focused Therapy* had 26 responses, *Exposure Therapy* with 25 responses, *Narrative Therapy* with 11 responses, *Psychoanalysis* with 10 responses, and *Play Therapy* which had nine responses. The remaining responses, 23 respondents selected *Other* and included the following treatment strategies:

Motivational Enhancement Therapy, Psychodynamic Psychotherapy, Psychoeducation, Psychodynamic Therapy, Behavioral Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Strength Focused Therapy, Feminist Family Therapy, Existential Therapy, Supportive Therapy, Acceptance and Commitment Therapy, Thought Field Therapy (TFT), Functional Analytic Psychotherapy (FAP), Emotion Focused Therapy (EFT), Mindfulness-based Therapy, Mindfulness-Based Cognitive Behavioral Therapy (MBCBT), Attachment Theory, Motivational Interviewing, Marriage and Family Therapy, Ego Psychology, Christian Faith-based strategies, Temperament Counseling, Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Relational Psychotherapy, and Family Systems.

Therapeutic Alliance

Figure 4 (n = 90) represents respondents selection to the question, "In your clinical practice, how important is the therapeutic alliance?" Response options included the following selections: *Very Important*, *Important*, *Neutral*, *Somewhat Important*, and *Never Important.* The minimum value was 1 for *Very Important*, the maximum value was 2 for *Important*, and the mean for this question was 1.11. All respondents who answered this question either selected *Very Important* or *Important*, with 80 stating it is *Very Important* and ten stating it is *Important*.

Figure 4. Respondents Perception of Importance Regarding Therapeutic Alliance (n = 90)



Initial Report Survey Summary. As shown in Appendix C, Survey Results Initial Report, a summary of all survey questions is provided that includes general response information such as number of responses, percentage of responses, minimum and maximum values, mean, variance, and standard deviation. All questions were answered based on a five-point Likert Scale with 1 being *Frequently*, 2 *Often*, 3 *Sometimes*, 4 *Rarely*, and 5 being *Never*. As a result, the minimum value for all responses in this section is 1, and the maximum for all responses in this section is 5. Below is a review of basic data from the Rupture section of the survey:

Recognizing Ruptures

With the Likert question examining the frequency of *overt expression of negative sentiments* (n = 85): one respondent (1.0%) indicated they *Frequently* recognized this form of rupture in practice, seven respondents (8.0%) selected *Often*, 28 (33.0%) selected *Sometimes*, 48 respondents (56.0%) selected *Rarely*, and one respondent (1.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 3.48.

With the Likert question examining the frequency of *indirect communication of negative sentiments or hostility* (n = 86): one respondent (1.0%) indicated they *Frequently* recognized this form of rupture in practice, nine respondents (10.0%) selected *Often*, 44 (51.0%) selected *Sometimes*, 29 respondents (34.0%) selected *Rarely*, and three respondents (3.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 3.28.

With the Likert question examining the frequency of *disagreement about goals or tasks of therapy* (n = 84): two respondents (2.0%) indicated they *Frequently* recognized this form of rupture in practice, four respondents (5.0%) selected *Often*, 39 (46.0%) selected *Sometimes*, 37 respondents (44.0%) selected *Rarely*, and two respondents (2.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 3.39.

With the Likert question examining the frequency of *compliance* (n = 84): two respondents (2.0%) indicated they *Frequently* recognized this form of rupture in practice, 11 respondents (13.0%) selected *Often*, 35 (42.0%) selected *Sometimes*, 29 respondents (35.0%) selected *Rarely*, and seven respondents (8.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 3.33.

With the Likert question examining the frequency of an *avoidance maneuver* (n = 84): 11 respondents (13.0%) indicated they *Frequently* recognized this form of rupture in practice, 22 respondents (26.0%) selected *Often*, 37 (44.0%) selected *Sometimes*, 12 respondents (14.0%) selected *Rarely*, and two respondents (2.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 2.67.

With the Likert question examining the frequency of *self-esteem-enhancing operations* (n = 83): eight respondents (10.0%) indicated they *Frequently* recognized this form of rupture in practice, 30 respondents (36.0%) selected *Often*, 40 (48.0%) selected *Sometimes*, four respondents (5.0%) selected *Rarely*, and one respondent (1.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 2.52.

With the Likert question examining the frequency of *nonresponsiveness to intervention* (n = 83): three respondents (4.0%) indicated they *Frequently* recognized this form of rupture in practice, 12 respondents (14.0%) selected *Often*, 58 (70.0%) selected *Sometimes*, 10 respondents (12.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this rupture was noticed in treatment. The mean for this question was 2.90.

Repairing Ruptures

With the Likert question examining the frequency of *repeating the therapeutic rationale* (n = 81): 29 respondents (36.0%) indicated they *Frequently* utilized this strategy in practice, 23 respondents (28.0%) selected *Often*, 27 (33.0%) selected *Sometimes*, two respondents (2.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.02.

With the Likert question examining the frequency of *changing task or goals* (n = 81): 21 respondents (26.0%) indicated they *Frequently* utilized this strategy in practice, 30 respondents (37.0%) selected *Often*, 26 (32.0%) selected *Sometimes*, three respondents (4.0%) selected *Rarely*, and one respondent (1.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.17.

With the Likert question examining the frequency of *clarifying misunderstandings at a surface level* (n = 81): 38 respondents (47.0%) indicated they *Frequently* utilized this strategy in practice, 31 respondents (38.0%) selected *Often*, 12 (15.0%) selected *Sometimes*, zero respondents (0.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 1.68.

With the Likert question examining the frequency of *exploring relational themes associated with the rupture* (n = 81): 12 respondents (15.0%) indicated they *Frequently* utilized this strategy in practice, 24 respondents (30.0%) selected *Often*, 29 (36.0%) selected *Sometimes*, 16 respondents (20.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.60.

With the Likert question examining the frequency of *linking the alliance rupture to common patters in a patient's life* (n = 81): 24 respondents (30.0%) indicated they *Frequently* utilized this strategy in practice, 23 respondents (28.0%) selected *Often*, 29 (36.0%) selected *Sometimes*, five respondents (6.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.19.

With the Likert question examining the frequency of a *new relational experience* (n = 80): 15 respondents (19.0%) indicated they *Frequently* utilized this strategy in practice, 22 respondents (28.0%) selected *Often*, 28 (35.0%) selected *Sometimes*, 14 respondents (18.0%) selected *Rarely*, and one respondents (1.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.55.

Resolving Ruptures

With the Likert question examining the frequency of *exploring with skillful tentativeness and emphasize one's own subjectivity* (n = 76): 26 respondents (34.0%) indicated they *Frequently* utilized this strategy in practice, 25 respondents (33.0%) selected *Often*, 22 (29.0%) selected *Sometimes*, three respondents (4.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.03.

With the Likert question examining the frequency of *not assuming a parallel with other relationships* (n = 75): 13 respondents (17.0%) indicated they *Frequently* utilized this strategy in practice, 15 respondents (20.0%) selected *Often*, 37 (49.0%) selected *Sometimes*, 10 respondents (13.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.59.

With the Likert question examining the frequency of *accepting responsibility* (n = 76): 37 respondents (49.0%) indicated they *Frequently* utilized this strategy in practice, 31 respondents (41.0%) selected *Often*, six (8.0%) selected *Sometimes*, two respondents (3.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 1.64.

With the Likert question examining the frequency of *Starting where you are* (n = 75): 12 respondents (16.0%) indicated they *Frequently* utilized this strategy in practice, 24 respondents (32.0%) selected *Often*, 26 (35.0%) selected *Sometimes*, 13 respondents (17.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.53.

With the Likert question examining the frequency of *Focusing on the concrete and specific* (n = 76): 26 respondents (34.0%) indicated they *Frequently* utilized this strategy in practice, 28 respondents (37.0%) selected *Often*, 20 (26.0%) selected *Sometimes*, two respondents (3.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 1.97.

With the Likert question examining the frequency of *evaluating and exploring patients' responses to interventions* (n = 76): 38 respondents (50.0%) indicated they *Frequently* utilized this strategy in practice, 28 respondents (37.0%) selected *Often*, 10 (13.0%) selected *Sometimes*, zero respondents (0.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 1.63.

With the Likert question examining the frequency of *clarifying or reflecting on the relational meaning of the therapist's intervention for both the patient and therapist* (n = 76): 26 respondents (34.0%) indicated they *Frequently* utilized this strategy in practice, 27 respondents (36.0%) selected *Often*, 20 (26.0%) selected *Sometimes*, three respondents (4.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.00.

With the Likert question examining the frequency of *establishing a sense of collaboration and we-ness* (n = 76): 44 respondents (58.0%) indicated they *Frequently* utilized this strategy in practice, 19 respondents (25.0%) selected *Often*, 12 (16.0%) selected *Sometimes*, one respondents (1.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 1.61.

With the Likert question examining the frequency of *judiciously disclosing and exploring your own experience* (n = 76): 23 respondents (30.0%) indicated they *Frequently* utilized this strategy in practice, 20 respondents (26.0%) selected *Often*, 26 (34.0%) selected *Sometimes*, seven respondents (9.0%) selected *Rarely*, and zero respondents (0.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.22.

With the Likert question examining the frequency of *expecting resolution attempts to lead to more ruptures, and expect to revisit ruptures* (n = 76): 12 respondents (16.0%) indicated they *Frequently* utilized this strategy in practice, 23 respondents (30.0%) selected *Often*, 32 (42.0%) selected *Sometimes*, seven respondents (9.0%) selected *Rarely*, and two respondents (3.0%) selected *Never* in response to how frequently this strategy was utilized in treatment. The mean for this question was 2.53.

Impact of Clinical Experience on Rupture Awareness**.** In order to measure one's level of understanding regarding ruptures within the therapeutic alliance and the sub-components therein, the independent variable reflecting respondents' years of clinical practice was selected to compare against the criteria described in the survey for recognizing, repairing, and resolving ruptures based on the hypothesis that years of practice will impact the clinicians understanding of ruptures. Two major tests were utilized, the chi-square (crosstabs) and correlations. The survey

responses for the sub-categories of ruptures are classified as an ordinal-level variable due to the variety of responses on the Likert scale that range from *Frequently* to *Never*. Initially, the Likert Scale responses were coded as: *Frequently* = 1, *Often* = 2, *Sometimes* = 3, *Rarely* = 4, *Never* = 5. The chi-square and the correlations test can only accommodate variables with 2-3 values in order to have the least minimal number of responses in a cell to be valid. The recognize, repair, and resolve sub-categories were first recoded as: *Frequently/Often* = 1, *Sometimes* = 2, *Rarely/Never* = 3, and then recoded again as *Frequently/Often/Sometimes* = 1, *Rarely/Never* = 2. Years of practice was recoded from 1 = 2-5 years, 2 = 6-10 years, 3 = 11-15 years, 4 = 16-20 years, and 5 = 20 + years to 1 = 2-10 years experience, 2 = 11-20 years experience, and 3 = 20 + years of experience.

Table 2 (Appendix B) shows that 15 respondents (60.0%) who reported 2-10 years of experience in the mental health field indicated that they had observed clients *Frequently*, *Often*, or *Sometimes* become compliant in their therapeutic interventions even when the client did not show interest, compared to 10 respondents (40.0%) who noticed this rupture marker *Rarely* or *Never*. For respondents who have 11-20 years of experience, 16 (72.7%) observed clients *Frequently*, *Often*, or *Sometimes* become compliant in their therapeutic interventions even when the client did not show interest, compared to 6 (27.3%) who noticed this rupture marker *Rarely* or *Never*. Finally, for respondents with 20 + years of experience, 8 (34.8%) observed clients *Frequently*, *Often*, or *Sometimes* become compliant in their therapeutic interventions even when the client did not show interest, compared to 15 (65.2%) who noticed this rupture marker *Rarely* or *Never*. This crosstabulation demonstrates that in the sample, those with fewer years of experience were more likely to observe clients becoming compliant with treatment as a form of a rupture as compared to those with 20 + years of experience who were less likely to notice

compliance as a issue within the therapeutic alliance. Table 3 shows that the p-value for the chi-square of the variables Years of Practice and R1 Compliance is .033. There is a statistically significant relationship between the year of experience of respondents and the frequency of the specific rupture marker of becoming compliant with treatment on the part of the client.

Table 3. *Chi-Square Tests for of Practice (Recoded) and R1Compliance (Recoded)*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.851[a]	2	.033
Likelihood Ratio	6.972	2	.031
Linear-by-Linear Association	2.887	1	.089
N of Valid Cases	70		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 9.74.

Table 5 (Appendix B) shows that 21 (84.0%) respondents who reported 2-10 years of experience in the mental health field, indicated that they had utilized linking the alliance rupture to common patterns in a clients life *Frequently, Often*, or *Sometimes*, compared to 14 (16.0%) who utilized this strategy *Rarely* or *Never* over the course of treatment. For respondents with 11-20 years of experience, 22 (100.0%) indicated that they had utilized linking the alliance rupture to common patterns in a clients life *Frequently, Often*, or *Sometimes*, compared to 0 (0.0%) who utilized this strategy *Rarely* or *Never* over the course of treatment. Finally, for respondents with 20+ years of experience, 23 (100.0%) indicated that they had utilized linking the alliance rupture to common patterns in a clients life *Frequently, Often*, or *Sometimes*, compared to 0 (0.0%) who utilized this strategy *Rarely* or *Never* over the course of treatment. This crosstabulation demonstrates that in the sample, clinicians with more years of experience are more likely to link the alliance rupture to common patterns in a client's life than clinicians with less than 10 years

experience. Table 6 shows that the p-value for the chi-square of the variables Years of Practice and R2 Link is .022. There is a statistically significant relationship between years of experience of respondents and the utilization of linking alliance ruptures to common patterns in a client's life.

Table 6. *Chi-Square Tests for of Practice (Recoded) and R2Link (Recoded)*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.636[a]	2	.022
Likelihood Ratio	8.681	2	.013
Linear-by-Linear Association	5.762	1	.016
N of Valid Cases	70		

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is 1.26.

Therapist Experience of Ruptures. The open-ended question asked respondents, *Could you briefly explain a situation in which a rupture occurred with one of your clients and how you recognized, repaired, and resolved the rupture?* This question was designed to get a baseline measurement for the personal experience of respondents regarding the different phases of a rupture event and to see how they recognized, resolved, and repaired the rupture. Since the themes were already identified as how to recognize ruptures, how to repair ruptures, and how to resolve ruptures, the qualitative data were then coded into these three main themes. As shown in Appendix C, a total of 61 respondents provided an example of how they handled a rupture event. Appendix D provides a summarized list of the qualitative data coded into the themes of Recognizing Ruptures, Repairing Ruptures, and Resolving Ruptures. The qualitative coding displays 116 respondent examples for Recognizing Ruptures, 108 respondent examples for Repairing Ruptures, and 93 respondent examples for Resolving Ruptures.

Recognizing Ruptures. According to the feedback from respondents, the method most used to establish if a rupture has occurred is by observing the client's behavior or physical response to the event. Respondents indicated that they would observe their clients become visibly distressed, distant, closed, reactant, disengaged and avoidant. Clients would express a varying range of emotions, such as anger, invalidated, enraged, and upset. Clients were also observed with the following behaviors, such as being late to session, cancelling or not showing for appointments, would limit responses in session, would make false promises to appease the therapist, become compliant with treatment, issue complaints against therapist to their supervisor, display a decrease in commitment, would pick fights with and avoid the therapist, clients would question the therapist (are they doing the right thing, do they know what they're doing), and not completing therapy assignments.

Repairing Ruptures. The most common form of a repair as indicated by respondents in this sample included simply naming the rupture with the client and allowing time for both the client and therapist to process what occurred within the rupture. The therapeutic dyad would acknowledge associated feelings surrounding rupture which would lead to a discussion of misperceptions, miscommunications, relational myths, and any transference or countertransference issues that would arise. Therapists would also assist the client in making connections between the rupture that occurred within therapy versus similar situations in the clients personal life in order to disrupt the cyclic pattern. Additionally, some therapists also noted that they took responsibility for the rupture by sharing with clients that they realized they were moving too fast for the client or did not properly explain the treatment intervention so the client could understand what was expected of them.

Resolving Ruptures. The most common response regarding how to resolve ruptures would be the collaborative effort between the client and therapist to either reestablish or review the treatment plan and goals, to reassess and restructure the treatment strategy to make it more aligned with the desires of the client, or work with the client to determine different methods of acknowledging a rupture had occurred by bringing it up, raising their hand, or contracted for in-session check-ins. According to the responses, resolving the rupture with the client almost always involved restoring the client's sense of power and control within the relationship by promoting the therapeutic relationship as a partnership.

Discussion

The purpose of this research was to determine the role and process of the therapist in recognizing, repairing, and resolving ruptures within the therapeutic alliance. Through the use of an anonymous survey, it was determined that the therapeutic alliance in itself is an important factor within a therapeutic relationship and that ruptures are a prominent aspect of any treatment strategy.

Sample

For the purpose of this study, it was most notable to identify the years of practice of the respondents as this was the primary variable used in inferential analyses. Although the response rate remained fairly consistent for the range of years of experience of respondents, 44% indicated they had 16 years of experience or more, making this sample a very experienced group in the mental health field. The high percentage of experienced professionals is a strength of this study because it targeted those that are more likely to have experienced ruptures within the therapeutic alliance firsthand and have the ability to provide direct reflection on the impact and strategies used therein. Due to the flux of incoming practitioners and those that either retire or leave the field, it is unknown if this pattern in the sample is comparable across health fields outside of this study. However, possible explanations may include retirement, a late start beginning in the field due to high degree requirement, increased burnout rate after extended years of service, or increased workload which does not allow extra time to participate in a survey such as this one.

Regarding the completion of the survey, although 100 surveys were started, only 48 were completed in its entirety. When viewing the response rate of each question from the beginning to the end of the survey, a pattern was identified where more respondents completed the

beginning questions of the survey with a few respondents dropping off for each question towards the end. This drop-out rate could be the result of many factors. The survey could be too long and take more than a reasonable amount of time to complete, which may have resulted in respondent fatigue in relation to both length and time, and may be related to the difficulty recalling sensitive topics, such as ruptures within the alliance. Additionally, although the specific types of rupture markers and strategies available were briefly defined in the survey, respondents may not fully understand the range of recognizing, repairing, and resolving ruptures in order to fully identify these themes in their practice.

Considering the gender disparity within helping professions as a whole, it was not surprising to acknowledge the imbalance between male and female respondents for the purposes of this study. The vast majority of respondents indicated their gender as female (62 responses) compared to their male counterparts (seven responses). Due to the level of experience required by a clinical mental health provider, it is reasonable to see that the majority of respondents indicated a master's level degree to be the highest degree achieved. A total of 53 respondents indicated this response in addition to 15 respondents who had a doctorate degree.

The range of treatment modalities respondents utilize in practice was rather exhaustive. Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) had the most responses of all modalities which may speak to the intention of these treatment strategies in identifying and addressing maladaptive thought processes and behaviors. As determined by this study, the most common forms of ruptures within the therapeutic alliance are a result of cognitive myths or cyclic behaviors that interfere with therapy. This finding was not expected because the concept of ruptures within the therapeutic alliance originated within the psychodynamic paradigm and particularly within DBT, ruptures are included under the umbrella

definition of therapy-interfering behaviors and not considered an isolated event within therapy. Furthermore, ruptures exist in all forms of therapy interventions and may vary based on the terminology used. The broad application of rupture recognition, repair, and resolve (regardless of what it is called), is fodder to support the importance of the alliance itself and the subsequent ruptures that are likely to occur.

Therapeutic Alliance

First, all respondents believed that the bond formed between the therapist and client to be an important aspect of any treatment intervention. Out of the 90 respondents who answered this question, 80 respondents stated the therapeutic alliance was *Very Important*, and 10 respondents indicated it was *Important*. No respondents selected *Neutral*, *Somewhat Important*, or *Never Important*. As supported by literature, the therapeutic alliance plays a major role in therapy and can impact the course of treatment interventions and therapeutic outcomes (Eubanks-Carter, Muran, & Safran, 2015; Gaztambide, 2012; Marmarosh, Schmidt, Pembleton et al., 2015; Martin, Garske, & Davis, 2000; Safran, Crocker, McMain, & Murry, 1990; Safran & Muran, 1996; Safran, Muran, & Eubanks-Carter, 2011; Safran, Muran, Wallner-Samstag, & Stevens, 2001). The results of this study confirm the importance of the therapeutic relationship; therefore it is reasonable to view ruptures, or breaks in the alliance, as equally important (Safran & Kraus, 2014).

The results identified within the quantitative portion of the survey directly relate and match the results of the open-answer qualitative responses, thus increasing the validity of the testing instrument. Based on both quantitative and qualitative results, it was determined that more clinicians are able to recognize, or identify, when a rupture has occurred as compared to the later stages of repairing and even less-so for resolving ruptures. The subsequent stages of

ruptures may require increased skill on the part of clinician to properly address the impasse and effectively modify treatment strategies to manage the rupture. On the other side of the spectrum, some clinicians may not realize there is more to managing ruptures than merely acknowledging that a rupture has occurred. Some clinicians may also fear stigma and judgments from peers related to ruptures and may not easily address these topics freely with colleagues, in consultation, or supervision.

Of all the rupture markers and strategies identified to repair and resolve breaks within the alliance, chi-square tests confirm that a relationship is evident. Specifically, years of practice for the clinician is related to observing clients become compliant with treatment, regardless of their interest in the intervention. Although the hypothesis was that as years of experience increase, the observation of clients becoming compliant would also increase, the results of this test demonstrate an inverse relationship where years of experience increase, the observation of compliance decreases. This outcome may relate to the perception and prioritization of the therapist. As experience increases, it is possible that some clinicians are more focused on the treatment modality, the next steps of the intervention, managing crises, or have come to realize that for many clients, becoming compliant is part of the process and no longer recognize it as a rupture in the alliance. Further defining the marker of compliance and how it presents in a range of clients may increase the understanding of mental health professionals in defining that this type of rupture has occurred. Compliance may be perceived as therapeutic change, a common state of the relationship or process, or clinicians may be hesitant to label the behavior as compliance due to the belief that a deeper issue may be at play.

The other significant chi-square result identified a relationship between years of practice for the clinician and the strategy of linking the rupture event to similar patterns in the client's

life. As predicted with the hypothesis and evidenced by the result, as years of experience increase, clinicians are more likely to make connections between rupture events in the therapeutic alliance and similar breaks in the client's personal life regardless of educational background of the respondent and the promotion of viewing the environment or the internal processes of the client. It is reasonable to assume that the longer clinicians stay in the mental health field, they are more likely to increase their knowledge and expertise through experience and continuing education that make it easier to identify when behaviors are being mirrored in multiple relationships. As referenced in the literature, this is a strategy that can be used to repair a rupture once it occurs by providing the client with new information regarding a recurrent trend or pattern that occurs within their relationships (Coutinho, Ribeiro, Hill, et al., 2011; Eubanks-Carter, Muran, & Safran, 2015). The therapist could then build upon self-awareness in order to prevent a similar rupture from occurring in the future, whether in therapy or in personal relationships.

Therapist Experience of Ruptures

The stages of ruptures were identified as themes when coding the qualitative data respondents provided in the open-answer question; these themes are defined as Recognizing Ruptures, Repairing Ruptures, and Resolving Ruptures. The qualitative responses were coded based on the congruence of the example provided in relation to the stage of the rupture it had occurred. Through the identification of these themes, a pattern emerged that supports the conclusion evidenced by the quantitative results. Similarly, respondents were able to provide more examples of events that were classified as Recognizing Ruptures by observing the clients shift in mood, affect, or negative response as compared to examples provided for the latter stages of a rupture event, repair and resolve. Based on a total of 61 responses to the open ended

question, *Could you briefly explain a situation in which a rupture had occurred with one of your clients and how you recognized, repaired, and resolved the rupture?*, 116 examples were provided for Recognizing Ruptures, as compared to 108 responses for Repairing Ruptures, and 93 responses for Resolving Ruptures.

Although a gap in research has been identified through this study regarding the stages of a rupture, many respondents reflected upon using a range of strategies and tools in order to address the breach in the relationship. Respondents were generally able to identify when a rupture occurred based on the behavior or emotion of the client. However, the majority of reflections involved a more severe rupture, few reflected on how a minor infraction could impact the relationship. It is possible that due to only having the option to reflect on one example, the more severe scenarios are more likely to come to mind. Additionally, it is interesting to note the most common forms of recognizing ruptures is when the client is angry, avoids the therapist, and mentally separates from therapy.

When repairing ruptures, the majority of respondents indicated processing the event and acknowledging the feelings of both the client and therapist during the event. Due to the variability in treatment modality and practicing background, further testing may be required to determine if this treatment strategy is truly part of the rupture repair process or simply a form of processing with the client the relational factors that occur within treatment. However, it is interesting to note that almost all respondents indicated that naming the rupture was the most effective choice in their example to repair the rupture.

It was surprising to hear the lack of response regarding utilizing supervision or case consultation to aid in the repair of relational strains. The use of these tools was not the focus of this research and can be vital to skillfully maintaining the therapeutic bond. It is possible that

more experienced clinicians have less opportunity for consultation and supervision due to managing a full caseload, no longer requiring that component for licensure or employment stipulations, or may be believe that it is simply part of the therapeutic process. Additionally, acknowledging that a rupture has occurred and taking responsibility for their role in the event can provoke shame and self-judgment for the therapist. At the risk of appearing vulnerable, incapable, and inattentive, some clinicians may internalize the rupture event and be reluctant to discuss the impact openly and be willing to hear feedback from others.

When addressing the stages of ruptures, the last phase, or resolving ruptures, seems to fall short in respondent examples. It is possible that clinicians are not taking the extra effort to reduce the likelihood of a rupture occurring again in the future, perhaps because rupture events are inevitable. It is also reasonable to assume that clinicians may fear the response the client has to offer about how to make changes in the alliance or the therapist themselves for a tighter bond. For some clinicians, it may be a matter of relinquishing some of their power and control within the relationship in order promote collaboration and teamwork within the treatment plan. Finally, the underrepresentation of resolving ruptures may be due to the preventative nature and potential for future rupture events. Once the rupture has been recognized and repaired, clinicians may underestimate the importance of taking the next step in an attempt to prevent future events from occurring and may skip this step because the turmoil is no longer imminently distressing.

Due to the wide array of rating tools available used to measure the therapeutic alliance (Elvins and Green, 2008, provides an exhaustive list of examples), it was surprising that only a few respondents mentioned utilizing these tools in session. The use of scales could greatly assist the clinician in recognizing, repairing, and resolving the ruptures that occur within the relationship. This variance could be due to the practice model utilized therapeutically as some

models encourage a check-in with the client as often as each session to hear how the process is going for the client and if they have any concerns. Although scales are easy to distribute, and typically simple to complete, they can be time consuming. Often the length of the session is not long enough to accommodate the needs of the client that day and have time to complete session rating tool. This concept may also be an assumption regarding the process of a therapeutic session and resistance to changing the previously established structure. The use of rating tools may also obstruct the flow of the session by removing the attention and direction from the client, to refocus on the therapist. As a result, the tool used to better understand the relational connection may actually be counterproductive to building a strong therapeutic alliance, or would take more time to build. Finally, agency standards also play a major role in the use of session rating tools. Some agencies may have separate staff, Patient Care Coordinators (PCC) as one example, whose primary role is to be a resource for the client, inquire about how the session went, receive feedback, and meet other needs for the client like scheduling future sessions or learning about other programs available to them.

Implications for Social Work

The results of this study emphasize and support the importance of building a strong therapeutic alliance and understanding the impact that ruptures can have on the relationship. For clinical social workers, this concept is fundamental to direct practice as it provides the keystone for initiating treatment and change, providing a supportive environment for the client to produce progressive outcomes, and it can provide crucial information regarding the problematic relational behaviors that clients seek help to properly manage and improve upon. Furthermore, the concept of alliance, and more specifically regarding ruptures within the alliance, is comparable across treatment modalities. Regardless of intervention strategy, social workers must understand the

role of ruptures within a therapeutic setting and how to effectively repair any impasse that has occurred. The latest treatment trend will not be as effective if the fundamental relationship between the client and therapist is not stable. Finally, social workers in general are skilled at viewing situations from a person-in-environment (PIE) perspective, and exploring relational deficits within the safety of the therapeutic relationship could provide more information regarding what clients experience in their personal lives. Similar to the Ecological Perspective, ruptures can provide social workers a wider lens and better a understanding of all the components regarding a client's problematic behavior or maladaptive thought processes in order to illicit change.

Limitations and Recommendations for Future Research

The intent of this research study was to gain a better understanding regarding the knowledge base of mental health professionals and their perception, knowledge, and skill as it relates to ruptures that occur within the therapeutic alliance. To this end, a limitation here is not having previous results or a similar study to review in order to modify and adapt the current study to decrease or eliminate issues that arise. Through the process of this study, insight regarding how to format the survey, which questions to ask, and locating a target demographic was gained which will be beneficial if this research is duplicated or elaborated upon.

The sample size was another major challenge to this study. Through the use of an international and local listserv, only 100 respondents attempted to complete the survey, with only 48 respondents completing the survey in its entirety. Having a larger sample size will increase the inferential analyses that can be applied which would then be more likely to produce significant and valid results. In order to increase the sample size, a variety of options are available. First, research funding would be beneficial as the majority of listservs require a fee in

order to access membership lists, and with a greater amount of listservs to market to, a larger and more diverse sample could be attained. Funding could also be used to offer an incentive or compensation for those who complete the study. The survey could also be open for a longer period of time to improve upon accessibility.

The survey instrument was also a limitation as evidenced by the drop-out rate of participates throughout the length of the survey. This pattern could be due to a variety of factors including respondent fatigue, length of time it takes to complete the survey, or not fully understanding the questions being asked. For future studies, it may be beneficial to break down the stages of ruptures and focus on one at a time. The layout of the survey could be improved upon to increase the awareness of the participant regarding the progress made while taking the survey, having the ability to take a break and return to complete, and offering an incentive that is given for responding to the survey in its entirety. Furthermore, the use of a mixed-method design has its pros and cons, and the methodology could be separated into separate surveys to make the survey less daunting for participants.

The use of a mixed-method design offers strengths and limitations in regards to research design. One strength of this design is that it offers a variety of methods to gather data relevant to the research topic, not to mention the opportunity for an increased amount of data to analyze and compare. Furthermore, the use of qualitative data, offers the opportunity to gather more specific information and personal recounts of the respondents. However, by using multiple methods in one study, the survey requires more time to complete and requires a thoughtful response of each subject in order to provide well-rounded data. When there are more data gathered, there are also more data to analyze, therefore creating more challenges on the part of the researcher. Finally, the use of qualitative data is not generalizeable to a greater population. The experiences shared

by a subject are uniquely their own and can be used to simply gather themes that correspond with the research topic. In order to reap the benefits of both types of research design, it may be more reasonable to complete a series of smaller studies that focus on one type of design to not only isolate the data being studied, and to make the process simpler.

Due to the gap in research regarding ruptures within the therapeutic alliance, it is possible that many clinicians have not experienced a rupture, not realize a rupture has occurred, or have proper knowledge or training on how to resolve it. Mental health practitioners are highly educated on the importance of the therapeutic alliance so the training and understanding of ruptures should be considered as, if not more, important than the alliance itself. Therefore, the responses (or lack of responses) of many participants may skew the data based on their assumptions on how they may handle the situation. In addition, mental health professionals may internalize the rupture increasing their shame and stigma with the event itself. This realization may lead these subjects to inaccurately reflect on the rupture as they experienced it instead of having the ability to view the event in the big picture and to apply what they experienced for future situations.

Conclusion

The purpose of this study was to gain a preliminary understanding on how mental health practitioners perceive the importance of the therapeutic alliance and how they understand the impact of ruptures on the relationship and therapeutic outcomes. More specifically, this study investigated the therapist's experience of the stages of a rupture within the alliance and how they were able to recognize, repair, and resolve the rupture that occurred. The therapeutic alliance has been considered an important aspect of therapy; however minimal research is available regarding what to do when that bond is broken. The goal of this research was to increase practical knowledge surrounding the alliance and offer education to effectively manage any challenges that arise. This study featured an anonymous survey that was designed using mixed-methodology incorporating the use of quantitative questions ranked on a Likert scale and the opportunity to provide qualitative feedback through the use of an open-answer question. The respondents that participated in this study were very experienced with 44% of respondents attesting to having 16 years or more within the mental health field.

A correlation was identified through the use of the mixed-method design in which responses for both quantitative and qualitative sections matched and reflected an increased understanding of recognizing ruptures as compared to the later stages of repairing and resolving ruptures. It may be concluded that therapists are more comfortable with and may already have a good knowledge base on how to determine when a rupture has occurred and be able to identify common characteristics to support the event, such as observing a change in the client's demeanor, affect, or behavior. Chi-square tests were utilized to determine if a relationship exists between respondent's years of experience and rupture markers or strategies. Two analyses produced significant results between two sets of variables, years of experience and the

recognition of the client become compliant with treatment and years of experience with linking the rupture event to similar situations in the client's personal life. these results indicate that years of experience of mental health practitioners does have an impact on how they perceive compliance or having the ability to link the rupture event to other relational patterns. Finally, all respondents from a range of practice modalities believed the therapeutic alliance to be a very important or important aspect of any therapeutic intervention when given the option to respond on a scale from very important to never important.

To conclude this study on recognizing, repairing, and resolving ruptures within the therapeutic alliance, a case example is shared to highlight the importance of the subject matter and to demonstrate how each stage of the rupture process is crucial to rebuilding the alliance. Due to advances in mental health treatments, the introductions of new strategies and theories, and a clearer understanding of diagnostic criteria for mental illness, it can be challenging to bring the focus back to the simplest element of treatment, the therapeutic alliance.

The following quote has been edited from its original version for grammar and length and can be reviewed in its entirety in Appendix C (number 33 of the qualitative section):

> "*After 19 months of stage 1 DBT treatment with a 24 yr old female client following successful elimination of suicidal behaviors, she continued intermittent self-harm behaviors which … started to increase in frequency; the client demonstrated an increase in resistance to using certain skills required for self-harm elimination; her outcome measures also began indicating a plateau in progress and most importantly, she began entering into sessions with an angry affect and body language, lots of silence and undertones of sarcasm in reference to most DBT skills, cognitive restructuring attempts and refused exposure exercises while insisting "I have done all this and it clearly doesn't work". After large doses of validation of her obvious frustration with her emotional pain that just wasn't remitting, and agreeing with her frustration regarding her apparent lack of progress, I initiated a 'heart to heart' conversation with her to remove the obvious elephant in the room, disclosed my own personal/emotional experience of working with her weekly and encouraged a dialogue of the potential … problem areas … that could be*

contributing to the problem. Client's initial reaction was relief; we used the 'Lack of Progress' worksheet and discovered the primary problem was "low readiness to change". The client admitted after much validation and compassionate responses from me, that deep down, she really did believe that her simple attendance each week "would somehow make me better; I don't actually want to change the way I think or my beliefs even though I know they're hurting me, it terrifies me to let go of them".

Our decision was to put her on a 3 week DBT-therapy vacation…She came back 3 weeks later-ready to work. That was a year ago and now, she's graduating with her MA and in a solid, healthy relationship … and using, although reluctantly, the deeper skills that are required for true, inner, change. No self-harm in one year, she's in stage 3 DBT and working on shame resilience and self compassion. Without that heart to heart and identification of the lack of progress, with solutions as well, I doubt she would have made it this far and would likely still be in/out of hospitals, or worse. I cannot speak enough to the importance of this topic!"

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Appendix A. SURVEY

Recognize, Repair, and Resolve:

Understanding Ruptures within the Therapeutic Alliance

INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating ruptures within the therapeutic alliance. This study is being conducted by Jessica Schmidt, a graduate student at St. Catherine University and the University of St. Thomas under the supervision of Michael Chovanec, a faculty member in the School of Social Work. You were selected as a possible participant in this research through membership of a professional listserv.

Background Information:

The purpose of this study is to gain a better understanding of how therapists recognize, repair, and resolve ruptures within the therapeutic alliance. Approximately 100 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to complete an online confidential survey that consists of 30 multiple-choice questions and one open-answer question. This study will take approximately 20 minutes to complete.

Risks and Benefits of being in the study:

The study has minimal risks to you as a participant and will require time to complete. Subjects, specifically mental health professionals, will be asked to reflect upon their practice relating to the therapeutic alliance they have with clients as well as the ruptures that occur within the relationship. Subjects may find these survey questions intrusive, and potentially induce feelings of vulnerability regarding their individual practice and how they handled the situation. In addition, subjects will be asked to provide examples of their experiences of the therapeutic alliance and ruptures and how they processed the event with their client. Subjects will not be asked for identifying information regarding the clients they reflect upon in their example.

There are no direct benefits or compensation to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

The researcher will keep the research results encrypted on their personal computer which requires password to log into. The researcher will finish analyzing the data by May 23rd, 2016; upon completion of the study, any identifying information will be destroyed.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with the researcher, St. Catherine University, or University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Jessica Schmidt, at schm1292@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Michael Chovanec at mgchovanec@stkate.edu, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

Statement of Consent:

You are making a decision whether or not to participate. By proceeding with the survey, you acknowledge that you have read this information and your questions have been answered.

Recognize, Repair, and Resolve:

Understanding Ruptures within the Therapeutic Alliance

This survey consists of 30 multiple-choice questions and one open-answer question that will take approximately 20 minutes to complete. The survey is divided into subsections in order to gain a better understanding regarding the ruptures that occur within the therapeutic alliance; definitions are provided for each section.

- For the multiple-choice questions, please reflect on your clinical practice by selecting the most appropriate response based on your experience; your response will be based on a Likert scale that offers a range of options to choose from, such as Very Important to Never Important or Frequently to Never.
- The open-ended question asks you to reflect on one experience you have had with a client and how you were able to recognize, repair, and resolve the rupture that occurred within the relationship. Your personal feedback regarding ruptures is important in understanding the impact on the therapeutic relationship.
- A demographic section is included, which is optional to complete, however, you are encouraged to provide information regarding yourself and your practice as it will be useful in making comparisons amongst all participants of this study. All information gathered as a part of this study will be confidential.

Therapeutic Alliance

For the purpose of this survey, the therapeutic alliance refers to the bond or connection held between the therapist and client in a clinical setting.

1. In your clinical practice, how important is the therapeutic alliance?

    - Very Important
    - Important
    - Neutral
    - Sometimes Important
    - Never Important

Ruptures within the Therapeutic Alliance

For the purposes of this survey, a rupture refers to situations or circumstances that arise within the therapeutic alliance that can negatively impact the bond or connection between the therapist and the client in a clinical setting.

Recognizing Ruptures

For the purposes of this survey, recognizing ruptures refers to the acknowledgement or identification of an impasse, disagreement, or tension between a client and therapist.

2. How often have you experienced any of the following types rupture markers in your practice?

A. Overt expression of negative sentiments: When a client overtly expresses negative feedback towards the therapist through means of accusations, attacks, or ill will.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

B. Indirect communication of negative sentiments or hostility: When a client shows negative sentiments towards the therapist indirectly using sarcasm, nonverbal cues, or passive-aggressive behavior.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

C. Disagreement about goals or tasks of therapy: When a client disagrees, questions, or rejects the treatment strategy employed by the therapist.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

D. *Compliance*: When a client gives in and relents to various aspects of treatment even thought they did not indicate any interest in certain therapeutic activities.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes

- Rarely
- Never

E. Avoidance maneuver: When a client avoids interventions presented by the therapist by changing topics, refusing to explore topics at greater depth, or ignores the therapist.

- Frequently
- Often
- Sometimes
- Rarely
- Never

F. Self-esteem-enhancing operations: When a client attempts to provide explanations for their behaviors as a means of defending their situation.

- Frequently
- Often
- Sometimes
- Rarely
- Never

G. Nonresponsiveness to intervention: When clients do not positively respond to intervention or utilize the treatment strategy being used.

- Frequently
- Often
- Sometimes
- Rarely
- Never

Repairing Ruptures

For the purposes of this survey, repairing ruptures refers to the efforts made within the therapeutic dyad to understand what caused the tension within the relationship and to make steps to repair and rebuild the therapeutic alliance.

3. How often have you utilized the following intervention strategies when a rupture has occurred in your clinical practice?

A. *Repeating the therapeutic rationale*: Reviewing the treatment plan and goals of treatment, expectations of the client and therapist, and acknowledging the progress made thus far.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

B. *Changing task or goals*: Modifying tasks or goals to make the intervention strategies more accessible and meaningful for the client.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

C. *Clarifying misunderstandings at a surface level*: Addressing changes in the client's demeanor, confusion, or maladaptive thought processes in session as it happens.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

D. *Exploring relational themes associated with the rupture*: Once a rupture is addressed at the surface level, inquire about other relational aspects that could be related to the rupture. Such as, clients experiencing difficulty working with a specific gender, therapists in general, authority figures, etc.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

E. *Linking the alliance rupture to common patterns in a patient's life*: Identifying similarities between ruptures that have occurred in session that are mirrored in a client's personal relationships.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely

- Never

F. *New relational experience*: When the therapist can hypothesize relevant strategies, often without knowledge of the underlying themes or meaning to the client, and use these methods as a way of offering the client a new relational experience.

- Frequently
- Often
- Sometimes
- Rarely
- Never

Resolving Ruptures

For the purposes of this survey, resolving ruptures refers to the ongoing maintenance of the therapeutic relationship and the steps taken in an effort to prevent a future rupture from occurring.

4. In order to resolve ruptures and reduce the likelihood of another rupture occurring, how often have you utilized the following strategies in your clinical practice?

A. *Explore with skillful tentativeness and emphasize one's own subjectivity*: When therapists explore any relational deficits in a curious fashion in order to invite and engage with the client through the therapeutic process.

- Frequently
- Often
- Sometimes
- Rarely
- Never

B. *Do not assume a parallel with other relationships*: When therapists do not jump to assumptions regarding the client's personal life, but instead, view the rupture as an independent event.

- Frequently
- Often
- Sometimes
- Rarely
- Never

C. *Accept responsibility*: When the therapist is self-aware of how they contribute to the relationship and take responsibility for contributions when necessary by taking an open and nondefensive stance.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

D. *Start where you are*: When the therapist treats each session independently, is present in the moment, and does not allow what happened in the previous session to carry over to the next.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

E. *Focus on the concrete and specific*: When therapists do not rely on generalizations, but instead, focus on questions, observations, and comments that are based on specific events or examples as they relate to the client.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

F. *Evaluate and explore patients' responses to interventions*: When the therapist monitors the level to which a client seems involved or engaged to their treatment intervention and makes changes or adaptations as necessary.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

G. *Clarify or reflect on the relational meaning of the therapist's intervention for both the patient and therapist*: When therapists recognize that treatment modalities can vary in effectiveness for both the client and therapist and evaluate

interventions for unique complexities that may be related back to themselves or the client.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

H. *Establish a sense of collaboration and we-ness*: When therapists validate the concerns and feelings of the client during the rupture and emphasize that the event happened to the relationship as a whole and is therefore a shared dilemma.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

I. *Judiciously disclose and explore your own experience*: When the therapist discloses feelings they experience as they relate to the rupture.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

J. *Expect resolution attempts to lead to more ruptures, and expect to revisit ruptures*: When the therapist is aware and prepared for the discussion of a rupture to possibly trigger another impasse or rupture event.

- ▫ Frequently
- ▫ Often
- ▫ Sometimes
- ▫ Rarely
- ▫ Never

<u>Therapist Experience of Ruptures</u>

5. Could you briefly explain a situation in which a rupture occurred with one of your clients and how you recognized, repaired, and resolved the rupture?

- ▫ OPEN ANSWER

Demographics

The following questions are optional; however, this additional information will provide greater insight and opportunities for comparisons across demographic samples.

6. I am a:

- ▫ Male
- ▫ Female
- ▫ Other

7. I am:

- ▫ <25
- ▫ 26-30
- ▫ 31-35
- ▫ 36-40
- ▫ 41-45
- ▫ 46-50
- ▫ 51-55
- ▫ 56-60
- ▫ >61

8. The highest degree I have received is:

- ▫ Bachelors
- ▫ Masters
- ▫ Doctorate
- ▫ Other:

9. I have been a mental health practitioner for:

- ▫ 2-5 Years
- ▫ 6-10 Years
- ▫ 11-15 Years
- ▫ 15-20 Years
- ▫ >21 Years

10. I am licensed as a:

- ▫ Social Worker
  - o LSW
  - o LGSW
  - o LISW
  - o LICSW

- Psychologist
  - LP
- Counselor
  - LMFT
  - LPC
  - LPCC
  - LIDC
- Tribal Mental Health Practitioner
- Other:
- None

38. What treatment modalities do you utilize in your practice?

    Please check all that apply:

- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Psychoanalysis
- Play Therapy
- Narrative Therapy
- Solution-Focused Therapy
- Exposure Therapy
- Other:

THANK YOU!

You have now completed the survey! Thank you for your participation!

Please keep the discussion going by forwarding the email (with the link to the survey) to your peers and colleagues!

If you are interested in receiving a summary of the results of this research study, please contact the researcher at schm1292@stthomas.edu.

Appendix B. TABLES AND FIGURES

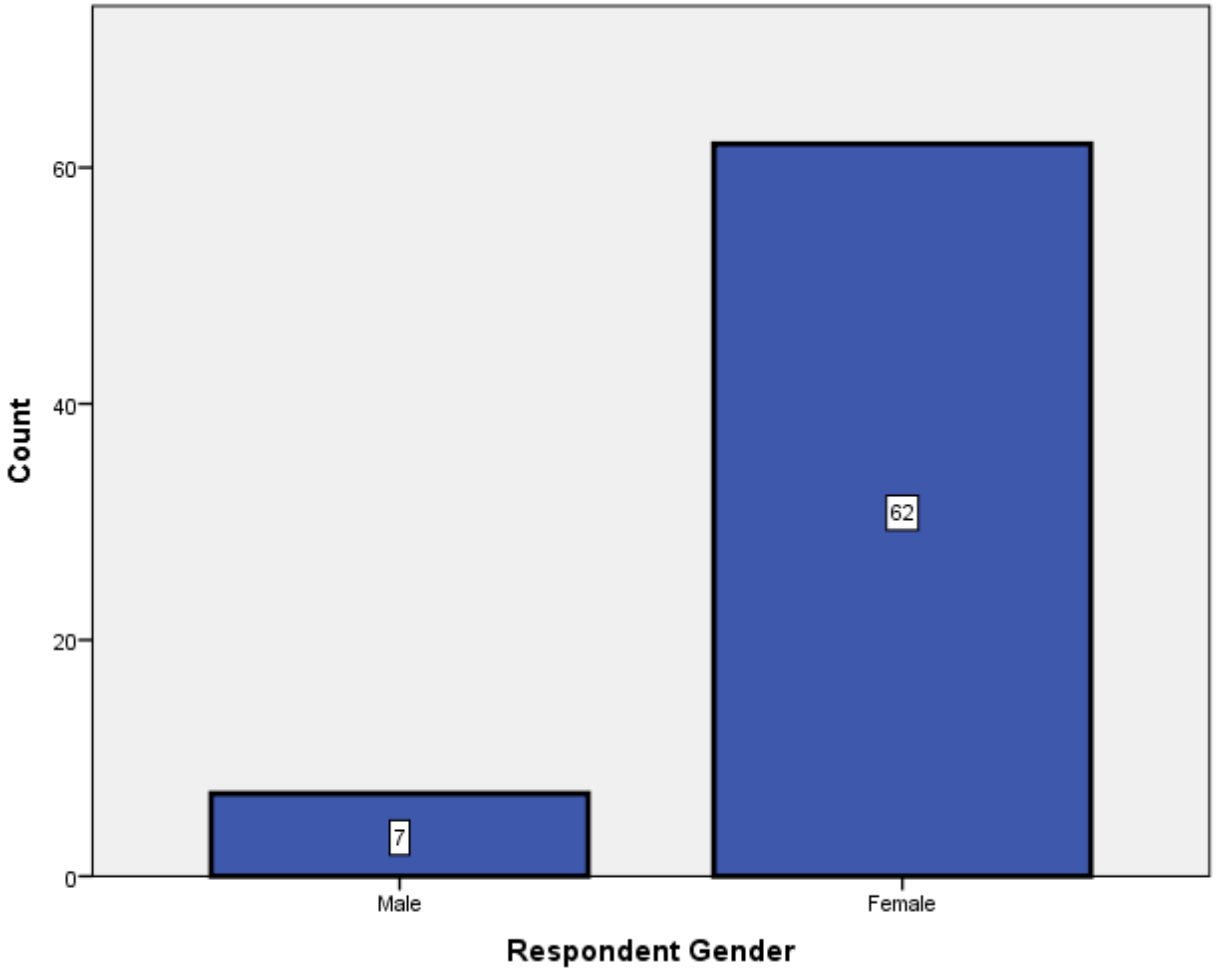


Figure 1. Respondent Gender (n = 69)

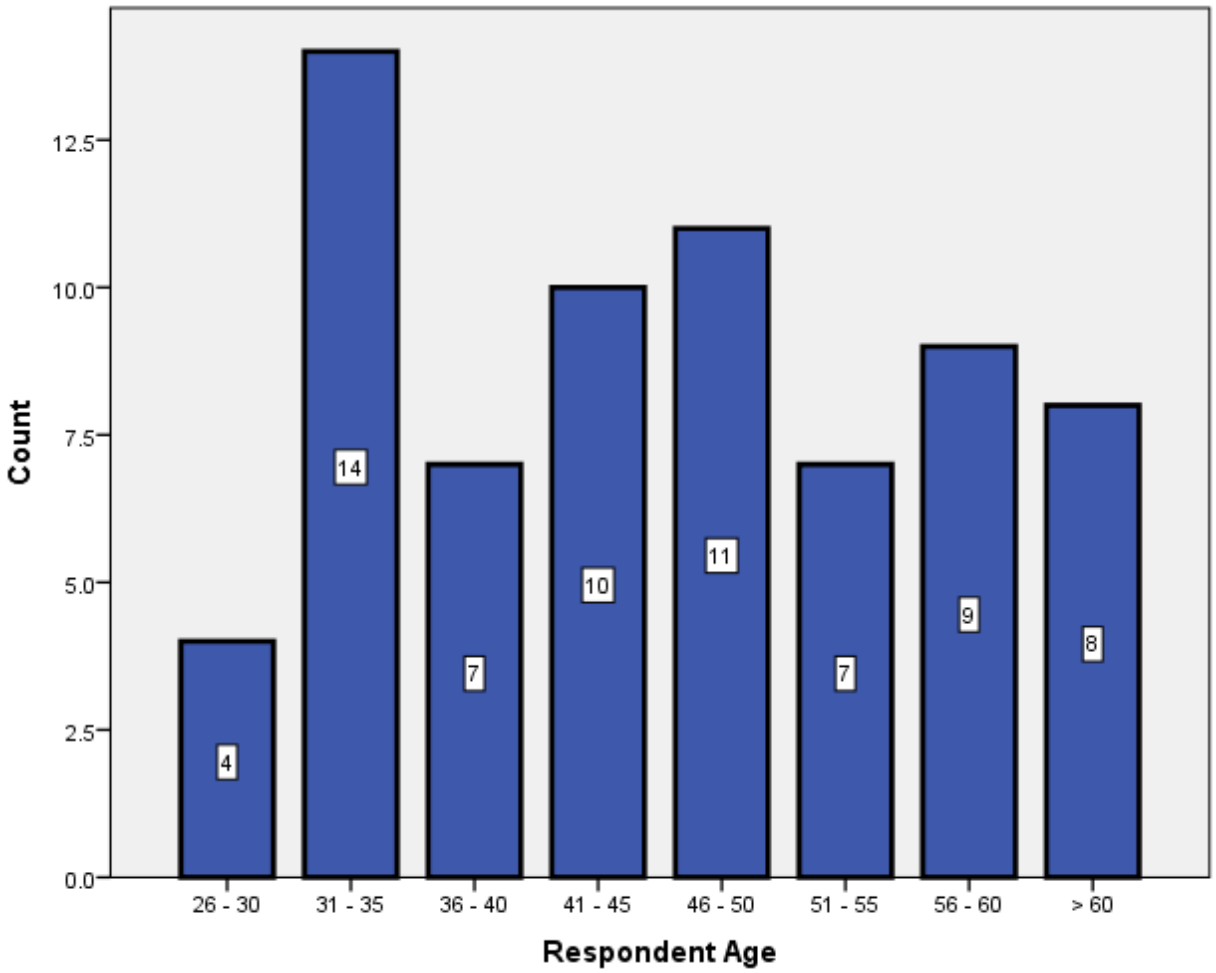


Figure 2. Respondent Age (n = 70)

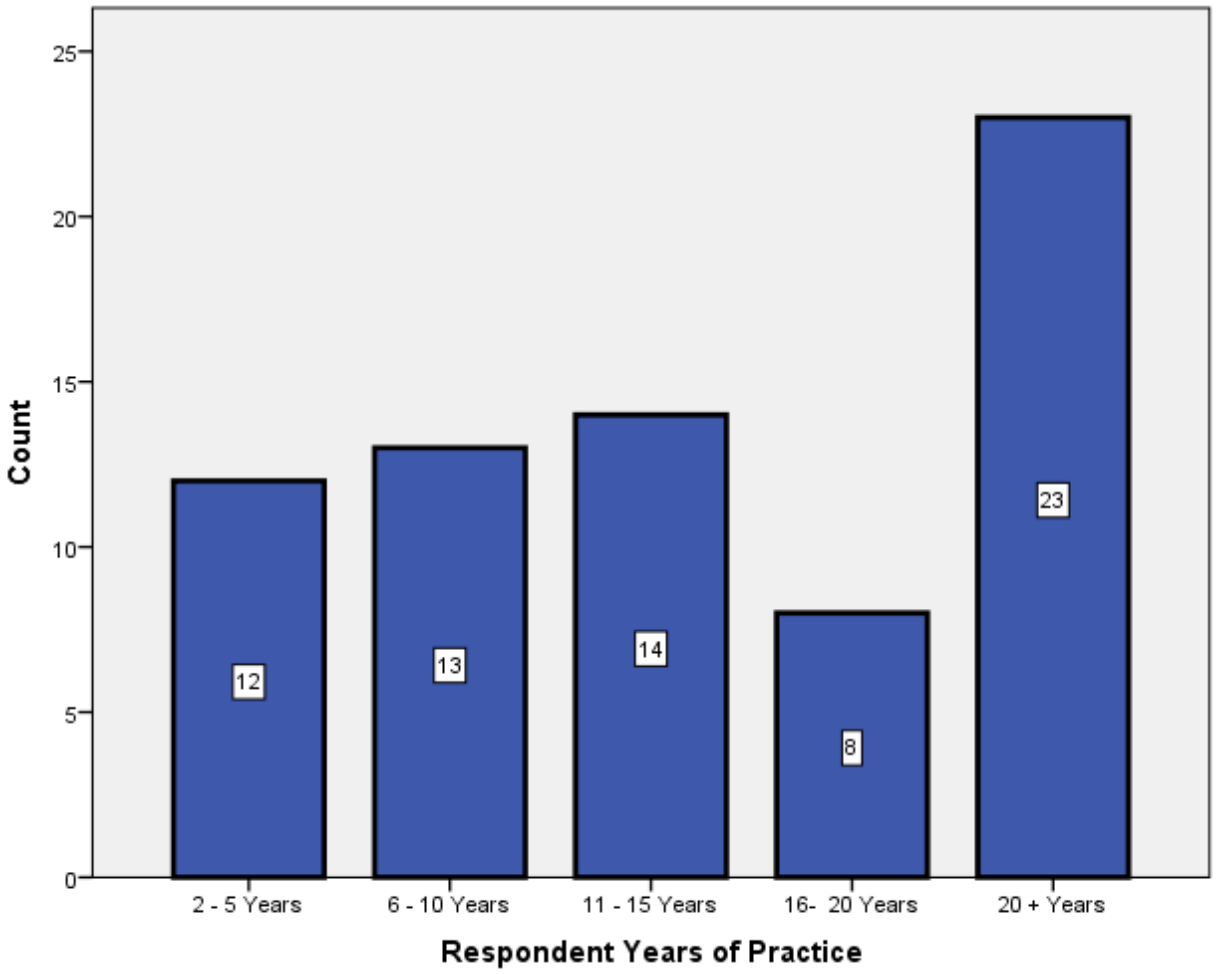


Figure 3. Respondent Years of Practice (n = 70)

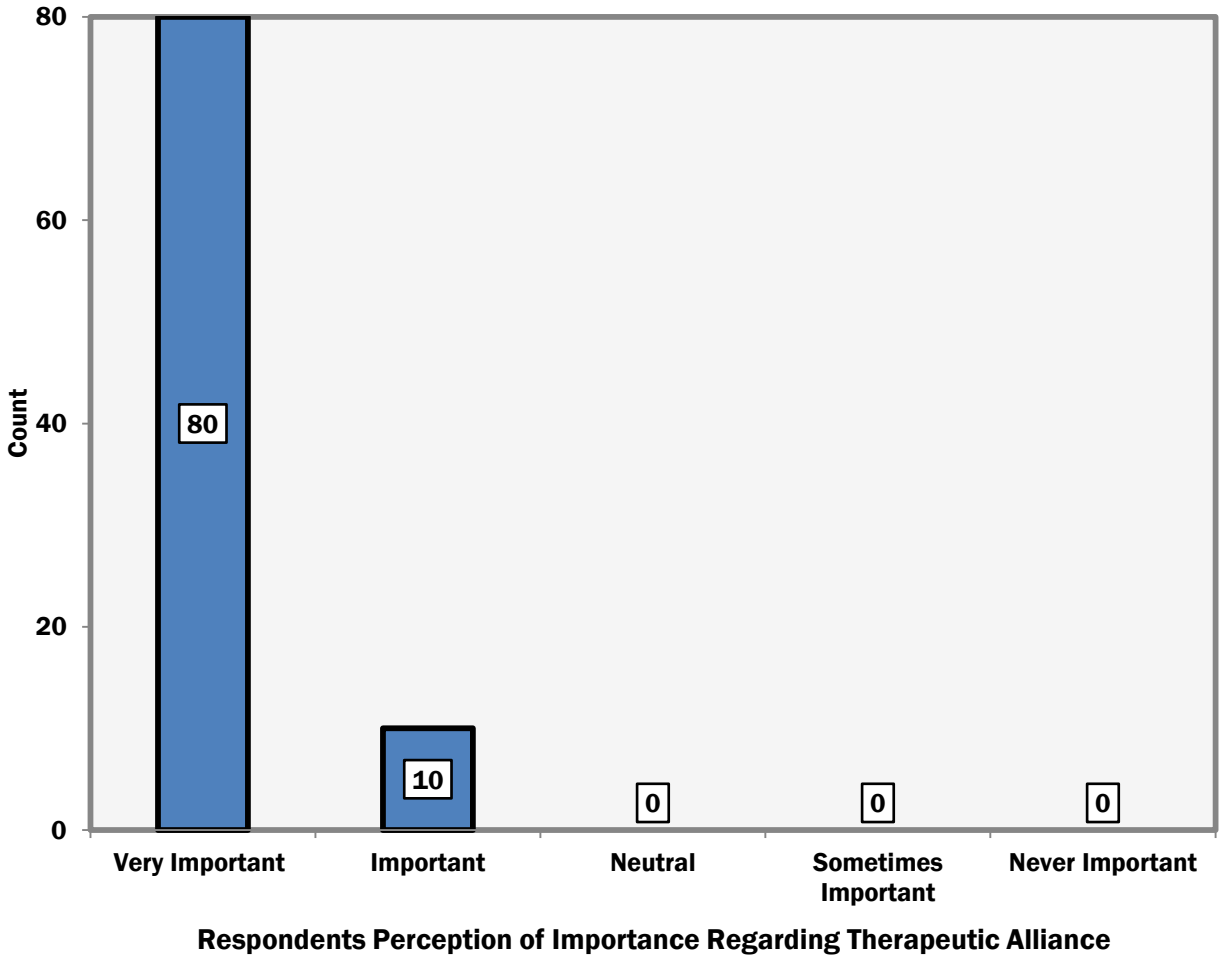


Figure 4. Respondents Perception of Importance Regarding Therapeutic Alliance (n = 90)

Table 1. *Case Processing Summary for Years of Practice (Recoded) and R1Compliance (Recoded)*

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
YearsOfPractice Recoded * R1ComplianceRECODED Reverse Recoded	70	69.3%	31	30.7%	101	100.0%

Table 2. *Crosstabulation for Years of Practice (Recoded) and R1Compliance (Recoded)*

YearsOfPractice Recoded * R1ComplianceRECODED Reverse Recoded Crosstabulation

			R1ComplianceRECODED Reverse Recoded		
			1.00	2.00	Total
YearsOfPractice Recoded	1.00	Count	15	10	25
		Expected Count	13.9	11.1	25.0
		% within YearsOfPractice Recoded	60.0%	40.0%	100.0%
		% within R1ComplianceRECODED Reverse Recoded	38.5%	32.3%	35.7%
		% of Total	21.4%	14.3%	35.7%
	2.00	Count	16	6	22
		Expected Count	12.3	9.7	22.0
		% within YearsOfPractice Recoded	72.7%	27.3%	100.0%
		% within R1ComplianceRECODED Reverse Recoded	41.0%	19.4%	31.4%
		% of Total	22.9%	8.6%	31.4%
	3.00	Count	8	15	23
		Expected Count	12.8	10.2	23.0
		% within YearsOfPractice Recoded	34.8%	65.2%	100.0%
		% within R1ComplianceRECODED Reverse Recoded	20.5%	48.4%	32.9%
		% of Total	11.4%	21.4%	32.9%
Total		Count	39	31	70
		Expected Count	39.0	31.0	70.0
		% within YearsOfPractice Recoded	55.7%	44.3%	100.0%
		% within R1ComplianceRECODED Reverse Recoded	100.0%	100.0%	100.0%
		% of Total	55.7%	44.3%	100.0%

Table 3. *Chi-Square Tests for of Practice (Recoded) and R1Compliance (Recoded)*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.851[a]	2	.033
Likelihood Ratio	6.972	2	.031
Linear-by-Linear Association	2.887	1	.089
N of Valid Cases	70		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 9.74.

Table 4. *Case Processing Summary for Years of Practice (Recoded) and R2Link (Recoded)*

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
YearsOfPractice Recoded * R2LinkRECODED Reverse Recoded	70	69.3%	31	30.7%	101	100.0%

Table 5. *Crosstabulation for Years of Practice (Recoded) and R2Link (Recoded)*

YearsOfPractice Recoded * R2LinkRECODED Reverse Recoded Crosstabulation

			R2LinkRECODED Reverse Recoded		
			1.00	2.00	Total
YearsOfPractice Recoded	1.00	Count	21	4	25
		Expected Count	23.6	1.4	25.0
		% within YearsOfPractice Recoded	84.0%	16.0%	100.0%
		% within R2LinkRECODED Reverse Recoded	31.8%	100.0%	35.7%
		% of Total	30.0%	5.7%	35.7%
	2.00	Count	22	0	22
		Expected Count	20.7	1.3	22.0
		% within YearsOfPractice Recoded	100.0%	0.0%	100.0%
		% within R2LinkRECODED Reverse Recoded	33.3%	0.0%	31.4%
		% of Total	31.4%	0.0%	31.4%
	3.00	Count	23	0	23
		Expected Count	21.7	1.3	23.0
		% within YearsOfPractice Recoded	100.0%	0.0%	100.0%
		% within R2LinkRECODED Reverse Recoded	34.8%	0.0%	32.9%
		% of Total	32.9%	0.0%	32.9%
Total		Count	66	4	70
		Expected Count	66.0	4.0	70.0
		% within YearsOfPractice Recoded	94.3%	5.7%	100.0%
		% within R2LinkRECODED Reverse Recoded	100.0%	100.0%	100.0%
		% of Total	94.3%	5.7%	100.0%

Table 6. *Chi-Square Tests for of Practice (Recoded) and R2Link (Recoded)*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.636[a]	2	.022
Likelihood Ratio	8.681	2	.013
Linear-by-Linear Association	5.762	1	.016
N of Valid Cases	70		

a. 3 cells (50.0%) have expected count less than 5. The minimum expected count is 1.26.

Appendix C. SURVEY RESULTS INITIAL REPORT

Initial Report

Last Modified: 04/17/2016

1. In your clinical practice, how important is the therapeutic alliance?

#	Answer		Response	%
1	Very Important		80	89%
2	Important		10	11%
3	Neutral		0	0%
4	Sometimes Important		0	0%
5	Never Important		0	0%
	Total		90	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.11
Variance	0.10
Standard Deviation	0.32
Total Responses	90

2. A. Overt expression of negative sentiments: When a client overtly expresses negative feedback towards the therapist through means of accusation, attacks, or ill will.

#	Answer		Response	%
1	Frequently		1	1%
2	Often		7	8%
3	Sometimes		28	33%
4	Rarely		48	56%
5	Never		1	1%
	Total		85	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.48
Variance	0.51
Standard Deviation	0.72
Total Responses	85

3. B. Indirect communication of negative sentiments or hostility: When a client shows negative sentiments towards the therapist indirectly using sarcasm, nonverbal cues, or passive-aggressive behavior.

#	Answer		Response	%
1	Frequently		1	1%
2	Often		9	10%
3	Sometimes		44	51%
4	Rarely		29	34%
5	Never		3	3%
	Total		86	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.28
Variance	0.56
Standard Deviation	0.75
Total Responses	86

4. C. Disagreement about goals or tasks of therapy: When a client disagrees, questions, or rejects the treatment strategy employed by the therapist.

#	Answer		Response	%
1	Frequently		2	2%
2	Often		4	5%
3	Sometimes		39	46%
4	Rarely		37	44%
5	Never		2	2%
	Total		84	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.39
Variance	0.53
Standard Deviation	0.73
Total Responses	84

5. D. Compliance: When a client gives in and relents to various aspects of treatment even though they did not indicate any interest in certain therapeutic activities.

#	Answer		Response	%
1	Frequently		2	2%
2	Often		11	13%
3	Sometimes		35	42%
4	Rarely		29	35%
5	Never		7	8%
	Total		84	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.33
Variance	0.80
Standard Deviation	0.90
Total Responses	84

6. E. Avoidance maneuver: When a client avoids interactions presented by the therapist by changing topics, refusing to explore topics at greater depth, or ignores the therapist.

#	Answer		Response	%
1	Frequently		11	13%
2	Often		22	26%
3	Sometimes		37	44%
4	Rarely		12	14%
5	Never		2	2%
	Total		84	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.67
Variance	0.92
Standard Deviation	0.96
Total Responses	84

7. F. Self-esteem-enhancing operations: When a client attempts to provide explanations for their behaviors as a means of defending their situation.

#	Answer		Response	%
1	Frequently		8	10%
2	Often		30	36%
3	Sometimes		40	48%
4	Rarely		4	5%
5	Never		1	1%
	Total		83	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.52
Variance	0.62
Standard Deviation	0.79
Total Responses	83

8. G. Nonresponsiveness to intervention: When clients do not positively respond to intervention or utilize the treatment strategy being used.

#	Answer		Response	%
1	Frequently		3	4%
2	Often		12	14%
3	Sometimes		58	70%
4	Rarely		10	12%
5	Never		0	0%
	Total		83	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.90
Variance	0.41
Standard Deviation	0.64
Total Responses	83

9. A. Repeating the therapeutic rationale: Reviewing the treatment plan and goals of treatment, expectations of the client and therapist, and acknowledging the progress made thus far.

#	Answer		Response	%
1	Frequently		29	36%
2	Often		23	28%
3	Sometimes		27	33%
4	Rarely		2	2%
5	Never		0	0%
	Total		81	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.02
Variance	0.80
Standard Deviation	0.89
Total Responses	81

10. B. Changing task or goals: Modifying tasks or goals to make the intervention strategies more accessible and meaningful for the client.

#	Answer		Response	%
1	Frequently		21	26%
2	Often		30	37%
3	Sometimes		26	32%
4	Rarely		3	4%
5	Never		1	1%
	Total		81	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.17
Variance	0.82
Standard Deviation	0.91
Total Responses	81

11. C. Clarifying misunderstandings at a surface level: Addressing changes in the clients demeanor, confusion, or maladaptive thought processes in session, as it happens.

#	Answer		Response	%
1	Frequently		38	47%
2	Often		31	38%
3	Sometimes		12	15%
4	Rarely		0	0%
5	Never		0	0%
	Total		81	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.68
Variance	0.52
Standard Deviation	0.72
Total Responses	81

12. D. Exploring relational themes associated with the rupture: Once a rupture is addressed at the surface level, inquire about other relational aspects that could be related to the rupture. Such as, clients experiencing difficulty working with a specific gender, therapist in general, authority figures, etc.

#	Answer		Response	%
1	Frequently		12	15%
2	Often		24	30%
3	Sometimes		29	36%
4	Rarely		16	20%
5	Never		0	0%
	Total		81	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.60
Variance	0.94
Standard Deviation	0.97
Total Responses	81

13. E. Linking the alliance rupture to common patterns in a patient's life: Identifying similarities between ruptures that have occurred in session that are mirrored in a clients personal relationships.

#	Answer		Response	%
1	Frequently		24	30%
2	Often		23	28%
3	Sometimes		29	36%
4	Rarely		5	6%
5	Never		0	0%
	Total		81	100%

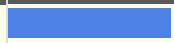
Statistic	Value
Min Value	1
Max Value	4
Mean	2.19
Variance	0.88
Standard Deviation	0.94
Total Responses	81

14. F. New relational experience: When the therapist can hypothesize relevant strategies, often without knowledge of the underlying themes or meaning to the client, and use these methods as a way of offering the client a new relational experience.

#	Answer		Response	%
1	Frequently		15	19%
2	Often		22	28%
3	Sometimes		28	35%
4	Rarely		14	18%
5	Never		1	1%
	Total		80	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.55
Variance	1.06
Standard Deviation	1.03
Total Responses	80

15. A. Explore with skillful tentativeness and emphasize one's own subjectivity: When therapists explore any relational deficits in a curious fashion in order to invite and engage with the client through the therapeutic process.

#	Answer		Response	%
1	Frequently		26	34%
2	Often		25	33%
3	Sometimes		22	29%
4	Rarely		3	4%
5	Never		0	0%
	Total		76	100%

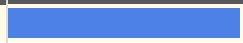
Statistic	Value
Min Value	1
Max Value	4
Mean	2.03
Variance	0.80
Standard Deviation	0.89
Total Responses	76

16. B. Do not assume a parallel with other relationships: When therapists do not jump to assumptions regarding the client's personal life, but instead, view the rupture as an independent event.

#	Answer		Response	%
1	Frequently		13	17%
2	Often		15	20%
3	Sometimes		37	49%
4	Rarely		10	13%
5	Never		0	0%
	Total		75	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.59
Variance	0.87
Standard Deviation	0.93
Total Responses	75

17. C. Accept responsibility: When the therapist is self-aware of how they contribute to the relationship and take responsibility for contributions when necessary by taking an open and nondefensive stance.

#	Answer		Response	%
1	Frequently		37	49%
2	Often		31	41%
3	Sometimes		6	8%
4	Rarely		2	3%
5	Never		0	0%
	Total		76	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	1.64
Variance	0.55
Standard Deviation	0.74
Total Responses	76

18. D. Start where you are: When the therapist treats each session independently, is present in the moment, and does not allow what happened in the previous session to carry over to the next.

#	Answer		Response	%
1	Frequently		12	16%
2	Often		24	32%
3	Sometimes		26	35%
4	Rarely		13	17%
5	Never		0	0%
	Total		75	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.53
Variance	0.93
Standard Deviation	0.96
Total Responses	75

19. E. Focus on the concrete and specific: When therapists do not rely on generalizations, but instead, focus on questions, observations. and comments that are based on specific events or examples as they relate to the client.

#	Answer		Response	%
1	Frequently		26	34%
2	Often		28	37%
3	Sometimes		20	26%
4	Rarely		2	3%
5	Never		0	0%
	Total		76	100%

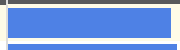
Statistic	Value
Min Value	1
Max Value	4
Mean	1.97
Variance	0.72
Standard Deviation	0.85
Total Responses	76

20. F. Evaluate and explore patients' responses to interventions: When the therapist monitors the level to which a client seems involved or engaged to their treatment intervention and makes changes or adaptations as necessary.

#	Answer		Response	%
1	Frequently		38	50%
2	Often		28	37%
3	Sometimes		10	13%
4	Rarely		0	0%
5	Never		0	0%
	Total		76	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.63
Variance	0.50
Standard Deviation	0.71
Total Responses	76

21. G. Clarify or reflect on the relational meaning of the therapist's intervention for both the patient and therapist: When therapists recognize that treatment modalities can vary in effectiveness for both the client and therapist and evaluate interventions for unique complexities that may be related back to themselves or the client.

#	Answer		Response	%
1	Frequently		26	34%
2	Often		27	36%
3	Sometimes		20	26%
4	Rarely		3	4%
5	Never		0	0%
	Total		76	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.00
Variance	0.77
Standard Deviation	0.88
Total Responses	76

22. H. Establish a sense of collaboration and we-ness: When therapists validate the concerns and feelings of the client during the rupture and emphasize that the event happened to the relationship as a whole and is therefore a shared dilemma.

#	Answer		Response	%
1	Frequently		44	58%
2	Often		19	25%
3	Sometimes		12	16%
4	Rarely		1	1%
5	Never		0	0%
	Total		76	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	1.61
Variance	0.64
Standard Deviation	0.80
Total Responses	76

23. I. Judiciously disclose and explore your own experience: When the therapist discloses feelings they experience as they relate to the rupture.

#	Answer		Response	%
1	Frequently		23	30%
2	Often		20	26%
3	Sometimes		26	34%
4	Rarely		7	9%
5	Never		0	0%
	Total		76	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.22
Variance	0.98
Standard Deviation	0.99
Total Responses	76

24. J. Expect resolution attempts to lead to more ruptures, and expect to revisit ruptures: When the therapist is aware and prepared for the discussion of a rupture to possibly trigger another impasse or rupture event.

#	Answer		Response	%
1	Frequently		12	16%
2	Often		23	30%
3	Sometimes		32	42%
4	Rarely		7	9%
5	Never		2	3%
	Total		76	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.53
Variance	0.92
Standard Deviation	0.96
Total Responses	76

25. Could you briefly explain a situation in which a rupture occurred with one of your clients and how you recognized, repaired, and resolved the rupture?

Text Response

1. I had an instance where I was over-pacing the client - that is - instead of staying with her I had leapt ahead - the experience was visceral during one session - it was like I was 1/2 mile down the road in front of her and suddenly realized her 'absence' - turned around and couldn't 'see' her - This was displayed by my client as disengagement during session, being late to session, and finally not showing up for a couple of sessions. We resolved the rupture by me naming it, taking responsibility for it, and acknowledging that while my enthusiasm for movement in therapy [my excitement when it happens] can be encouraging, it can also be overwhelming and negatively impact our relationship when I am in my own experience of "This is GREAT!" instead of staying with my client.

2. On a residential unit, an adolescent patient shoplifted razor blades while on a pass with parents and brought them onto the unit. She did not disclose having the razor blades and did not ask for help from staff prior to cutting in the unit bathroom. In the next individual therapy session, the patient was aware that I was disappointed from my demeanor. She felt hurt and stated that "people here don't have any right to be mad at me for this." The patient completed a behavioral chain analysis, and we had a dialog about the reasons for my reaction (i.e., concern for her and other patients' safety with blades on the unit; disappointment that she did not reach out for help; rupture in trust). She persisted in feeling that it was unfair for me and other staff to be disappointed or angry, but ultimately worked collaboratively with us on her goal to "get back on track" by identifying vulnerability factors and how to cope with them in the future and throwing herself back into treatment with a commitment to asking for help when needed. What seemed to help her do this was understanding that staff's reaction to her behavior was largely related to us caring about her welfare and being invested in her reaching her therapeutic goals.

3. two days ago a client cancelled a session with me because she didn't like that i used the phrase 'it's up to you' related with her picking which transportation she wanted to use to get to session. I decided to let her cancel and wait to hear back when she wanted to reschedule. She called the next day asking to keep the original appointment. We talked on the phone about why she'd been mad at my phrase. I said we couldn't have the original appointment back (it was still open but I decided that there might be some learning on the client's part that when she is angry and decides to cancel instead of trying to make a repair, there would be a consequence of a delay in a session) and we rescheduled for next week. Client on the phone seemed to be surprised that we couldn't keep the original appointment. But felt relieved that we could see each other next week. IN session we will talk about options for expressing anger or hurt and ways to do that in the client's best interest.

4. I work in a community mental health center and therefore have high volume of clients. I rarely have experienced a rupture that was not repairable. Most ruptures tend to be minor. A recent example involved a new intake. Client came in for her first apt and I noticed a distance in the session. She seemed defensive and presented with very flat affect. After the session I thought about what might be going on in the session. Although I do think the behavior is linked to some of her other relationships, I felt that she may be responding to me pushing to much for change right at the beginning. At the next session, I emphasized validation and noticed a slow shift in the relationship. We now have a great working relationship and she seems better able to tolerate when I push for change.

5. Client began limiting responses in the session. Introduced a strategy to assist in focusing, in relieving the stress of discussing difficulty subjects, etc. (coloring mandalas) to continue in the session. Explored whether client found the sessions to be too painful, to be ineffective, etc. Determined with client that the topics were overwhelming and raised past responses of running away. Developed a plan for initially limiting the amount of time spent on specific topics and gradually increase the time spent. Also discussed strategies for client to identify pro-actively when something arises that is painful, rather than shutting down.

6. Once, I made an offhand comment to a teenage client, and it was "Do you think anything in your life would ever mean as much as your commitment to horses?" The client, in the session following, said that really upset her because it sounded like I was minimizing her experience with working with horses. I explained that it wasn't my intent, and we processed how it felt invalidating to her, and then I restated what I meant by discussing that we were looking for other avenues of coping that might work just as well as riding/working with horses. That seemed to repair the rupture.

7. Client was angry, sarcastic, ended session early. I began the following session by acknowledging what happened and asked what she thought happened, so we could problem solve it in case it happened again.

8. Nearly four years ago I was in a session with a young woman (single white female, approx 35yo, struggling with addiction, Bipolar, BPD and bereavement over the loss of her infant son). She was difficult to engage and had cancelled or "no showed" for our first 5 initial appointments (I had not yet officially met her, she was recently assigned to me, I had only met her for about 2min when our program coordinator introduced us a few weeks back). The night before she finally attended a session with, I had to put my dog to sleep unexpectedly. In hind-sight, I should have taken the day off, but I did not want to cancel on her, hoping she would finally engage this time, so I went to work.. a "sobbing mess." Also in hind-sight, I was very frustrated with her, and was not fully aware of how frustrated I truly was. In short, I was not very empathetic, patient or validating during our session. I felt tension, but was not fully aware really where it was coming from. She left my office agreeing to come back, but I missed her closed and hurt body language and missed how invalidated I made her feel. She then complained about me to my supervisor. Thankfully, I had an amazing supervisor who sat me down (I rarely had any issues with clients). I cried. Realizing that A) I was so frustrated with her prior to meeting and that I should've addressed those feelings in supervision, and B) I should've taken the day off after putting my dog to sleep- which was really the main reason for the rupture. The next time I met with my client, I addressed this with her and was totally transparent about my dog and apologized for letting it effect me and our interactions. She appreciated my honesty and we ended up having a good therapeutic relationship.

9. Due to a health issue I needed to suspend my practice for a period of time. I met with each client to tell them and to plan. I also gave them a letter. One client was greatly distressed. In addition to making arrangements for her to see a colleague who practiced in the same office, the client and I agreed that she could come to the office and sit in the waiting room if and when she needed to. In th e course of a few weeks she used this 4-5 times and reported it was helpful. There were many times with this client thar a breach occurred in session. It required knowledge of the breach. We worked out a way for her to indicate that a breach had occurred. If she could not tell me verbally she would raise her left hand. We carefully explored what had occurred with particular emphasis on how it impacted her affectively. Also what early experiences it replicated. This work proceeded slowly over several years. The rupture/repair was an essential part of the healing process for this client

10. I am employed as a Primary Therapist at an inpatient psychiatric unit. Given the setting, clients are often reactant or do not want to be hospitalized. Further, symptoms (particularly those associated with psychosis) can impact a client's orientation and, in turn, their engagement and commitment to the therapeutic process. Given my role, interventions tend to be short-term, solution focused, and centered around problem solving. A scenario that frequently happens is I have to be the bearer of bad news so to speak where I inform clients that they will continue to remain hospitalized. This automatically causes a rupture in the relationship because I am no longer viewed as the individual who will advocate on their behalf but instead someone who has "betrayed" the client and is "forcing" them to remain hospitalized. When this occurs, I usually give the client space and welcome them to process when they feel comfortable. Almost always (so long as the client is oriented to reality), clients will return within minutes or hours in a place where they want someone to listen, talk to, and process with. So, the main impetus towards repair of the relationship is the setting (specifically the requirement to be hospitalized on a locked inpatient unit) and some time and space to process.

11. 14 year old client focused on his phone, playing a game and ignoring the fact that he is in my office and has real issues to address in a limited amount of time. I asked if he was using the game to avoid addressing the painful issues. He denied it, said he just liked the game, and asked if I wanted to play Backgammon, a game we have played pretty regularly.

12. I had a client tell me she felt I had invalidated her because I blocked her from interrupting her mother's comments. The client was angry with me. I validated that she was upset about being blocked and listened to her point of view. Afterwards, I shared the reasons why I had blocked her from interrupting. She was able to understand and was calmer after I had listened to her side.

13. During established therapy with a client, coached client to consider working through a grief/loss issue related to death of a parent. Client agreed to do so with writer for the next few sessions (appeared compliant). However, client began avoiding writer in the facility (work in a residential facility) and began missing appointments (rupture). (Repair) Spoke to client about this, who reported he/she is not ready to work on grief/loss right now. We discussed how it is okay to not work on this right now. We changed the therapy goals and transitioned into discussing abandonment (general terms) and connected how this could relate to grief/loss issues.

14. Ruptures and defenses on the part of the client are integral parts of the therapeutic work. Without them, there would be no exploration, no curiosity about expectations and therefore no growth. I had a client who often tried to pick fights with me. The content varied wildly but the upshot was that it was questioned whether I was the right therapist. Over time, with deeper awareness of this pattern, the client connected this with a refusal to accept the reality of the mothering received when the client was a child. The work then opened up in new ways which led to new life decisions and a more full life.

15. Long-term client began to verbalize what I called "disappointment" in the therapist's attentiveness and commitment to the therapeutic relationship. I restated the various upsets, offering compassion for the hurt/abandonment experienced as well as taking ownership for my part in the client's distress. I went on to help the client develop more ways to cope with disappointments in both our relationship and in other relationships. We contracted to check in at the end of each session to address any way that the client might have felt the session fell short of needs/wants so client would not be carrying that until the subsequent session. We also commenced each session with any update about where the therapeutic relationship stood at that point. The client appeared to develop increasing trust and

confidence in the therapy again with some limits I tie to the client's diagnostic profile.

16. Had a situation with a client who's support system was not supporting client in getting therapy. Instead were condemning client for "therapizing" them when she was trying to be skillful or ask questions of clarity. I was trying to work with getting the individual to agree to trying some tools over the week with family. The individual became angry with myself and informing me I was trying to ruin her relationships by having her do the homework assignment. She then went into some attacks on the type of therapy and approaches I used. I repaired the situation by first letting her vent. I then asked what had gone on for her that led to the reaction I received. We then had a conversation more in depth of what client was getting as comments and feed back from her family and support network. We did a check in if she felt things the same as her support network. She had responded "no" and she was scared to do anything with her friends and family. We then decided to change the approach and homework to be activities client does to work on her relationship with herself versus others at this time. She ended the situation with thanking me for listening to her and how she thought I would be like other professionals (therapists and doctors) she has worked with who would ignore her concerns and continue to push to stay on the same course of treatment.

17. I recognizes that I had pushed too hard for change when the client was more in a maintenance phase. I acknowledged that I should have interpreted and respected her subtle signs of "enough". I apologized and committed to changing focus on maintenance rather than change.

18. I was reviewing the DBT assumptions with my client when she became enraged by the assumption, "people are doing the best they can." After I tried to explain the befits to this assumption a million different ways, I realized that there was a bigger issue coming into play. After searching with the client how we got off track, I determined that I had not been properly oriented her to DBT, specifically exampling how and why the treatment works. I made a repair by explaining that I have tendency of getting a head of myself and where the client is at due to my enthusiasm to get started. I used a metaphor to encourage the client in "reeling me in when I go faster than she is ready for." The repair was effective in creating a safe environment for the client to express herself without becoming aggressive or avoidant which have been issues in other relationships.

19. The client wasn't bringing her diary card regularly to therapy even after we addressed it and chained it several times. I also tried various efforts to shape the behavior into occurring over the course of a few months. So, when none of that helped the behavior to happen, I put client on a vacation for 4 weeks and explained that I really wanted ct to come back and engage in therapy again, and when she did, client had to first hand me a completed diary card as she walked in the door at the start of every session. When client returned from the vacation, she was very upset, but handed therapist the diary card as requested. We reviewed the diary card, reviewed the importance of her doing the diary card, revisited her goals for therapy. Then, we addressed how angry and hurt she was with me (therapist) for "doing this to her". Client said that now she hears the word "vacation" and gets triggered. I validated how angry she was, it made sense to me that she was very angry to be asked to not come in for therapy when the time and the relationship with me is so important, that she didn't feel like I cared about her. She agreed that's how she felt. I then asked about her level of hurt and she agreed this was also an emotion she was feeling. I validated that this would have been very hurtful to not be able to see me and be connect to me when this relationship was very important to her. I let her know that the relationship was also important to me and that I had missed her. We checked in about her thoughts now about how important the diary card is to her treatment and her long term goals. She agreed she understood it was important to me, but she still wasn't convinced. She felt okay that I actually read it. I agreed that one

session when she was still angry wasn't going to really demonstrate anything. I asked for her commitment to still do the diary cards and could we check in about them in a few weeks to see what she thought about the "requirement". She was willing to keep doing them. I checked in with her after a few weeks; she had stopped bringing the dairy card in all crumpled up and shoved in her purse. She brought them in completed and flat (more protected) and she said that she was really beginning to understand how important they were to her. She had actually been afraid that I would ask her to do this and then never pay attention to the information or read it. She was glad to go over it at the start of each session. She was feeling more validated that I paid very careful attention to what she wrote and what happened during her week and she was finding the practice meaningful and she was making changes, using skills. We did really good work together and she made significant changes to her suicidal threatening behaviors.

20. A client whom I had previously seen in private practice became a client of the eating disorders service which I was working for. She was very angry with me at the session following the one in which I took her weight and height measurements. I resolved this by helping her to articulate that her anger was based on her fear that she would start to obsessively weigh herself again and that it had taken her a long time to stop doing that. Explained the importance of medical monitoring and reached an agreement that her GP would weigh her regularly as part of regular medical monitoring.

21. Recently working with a client with a diagnosis of BPD and PTSD who was fighting for custody of her children. She lost the custody battle and became very angry towards child protection and the therapist. She also became highly suicidal. She threatened to 'shoot a social worker' working in child protection and I had to break confidentiality to report threat to the social worker (duty of care) and had to make a mandatory firearms notification. She also reported blame towards therapist for not doing the 'correct therapy' and therefore contributing to her losing custody. Not long afterwards, the therapist had to advise the client that she was going on maternity leave. This triggered abandonment fears for the client and anger towards the therapist for 'stuffing things up' for the client and her treatment. The therapist then also had to advise the client who was in How did I resolve: - Whole team approach to encourage her to continue to attend weekly therapy sessions. - Validated her distress (not behavior) - Was open and honest with her re: mandatory notifications and the consequences of making specific threats to others. - Radical genuineness - Asked her about her 'blame towards the therapist' - she then disclosed that she was really blaming herself. - Highlighted her strengths and explored reasons for living - Discussed building a life worth living and encouraged to utilize distress tolerance skills - balanced validation vs problem solving - Assertively booking in appointments even when there had been several DNAs (post being advised of therapists pending maternity leave) - Therapist engaged in team treatment planning sessions, and increased peer supervision. Therapy concluded when the therapist went on maternity leave. A handover plan was put in place which the client accepted. Clients dysregulation had reduced (engaging in positive activities, problem solving, nil suicidal ideation reported) and there was no anger towards the therapist in the final sessions. She thanked the therapist for her support and wished her well as went onto maternity leave. Positive feedback was received from the mental health team about how the client was coping after therapy ceased. She had met with child protection and coped well (i.e. was assertive in communication and did not become dysregulated - contrast to previous pattern of behaviours)

22. Client is angry she cannot reach the therapist when she wants by phone. Discuss this with her and explain that her expectation is very high and related to the nonavailability of her mother in her childhood. You want it to be so good because it was so bad.

23. When a client interpreted my comment about mixing drugs & alcohol with psychotropic medication with defensiveness and said "I didn't like how you said that" , I explored what was coming up for her and also tried to explain where I was coming from while acknowledging & validating her feelings in light of how she was perceiving/interpreting what I was saying

24. After meeting with child for est. 10 sessions, and after more recent sessions of addressing the core emotional pain of loss of parents the Young child (5) yelled I don't want to come here anymore, this is boring in reference to therapy. This provider validated his anger and pain, asked about the possibility that therapy was boring because of how difficult it is to feel such grief. We discussed his options and highlighted the power he had to make the choices and encouraged him to continue using his voice to tell this provider his needs. I gave him the option of choosing the activity for next session.

25. The client discussed ending treatment but made superficial excuses regarding their reasons to consider ending. I questioned this in light of progress made and continuing themes to address. I invited client to consider topics discussed the week prior in relation to considering ending treatment, and questioned how it had felt to discuss these topics with me.. The client felt freed up to express concern I had been disappointed in them the week prior. I was able to address this concern and express I had not been disappointed and had instead been considering my impact on the client given many others in their life are experienced by client as unable to reflect on their impact on the client. This repaired the rupture, but I continue to listen for repeats/continuation of this theme that I am disappointed by this client.

26. Client brought to my attention that I had brought her situation form individual throat into the group therapy. And she felt a betrayal of trust. This happened over a year prior. However her work with relationships and self awareness made this interaction possible. She brought it to my attention and we explored her feelings and interpretations. Then we explored my intentions. We agreed upon a set of "guidelines " in the future to see if we could prevent the situation. And also agreed that if it were to happen even with this, she would bring it to me again, and when her feelings around this arose; she could bring it up to explore further.

27. A situation in group therapy where comments I and my co-facilitator made were misunderstood by several group members, who were already unhappy with the dynamics and discussions. The group confronted us. We encouraged them to discuss their feelings about the previous week, what they'd heard, what they thought we'd meant. We listened nondefensively, giving everyone the opportunity to say how they felt and reflecting back what they were saying, as well as writing suggestions for improvements in group process on the erasable board. One group member, who had been particularly difficult and defiant became much warmer and later started 1:1 therapy with me. She acknowledged that our/my handling of the confrontation had impressed her so much that she changed her mind about me.

28. I'm seeing a 14 yo teen with Aspergers. I was working with her on conversation and communication strategies when she became severely distressed and tearful. She cried and yelled at me for expecting things of her that she couldn't do. Obviously I attended to her distress and inquired of parallel experiences parents, teachers, therapists, friends, etc... She was able to acknowledge this and we worked through her experiences of difficulty understanding others' communications. I reassured her of my understanding and to stop me when she gets to a point where communication and understanding becomes confusing. This helped her with strategies and a sense of control w/out feeling shame and embarrassment for elements of her ASD.

29. A major rupture with one of my clients was when she asked me to fill out paperwork to apply for permanent disability benefits, which would involve me affirming that I believed she could not work. I validated her desire for these benefits but reiterated that (as I had told her previously) I believed she was able to work and would like to help her with that through therapy. She became very angry with me and criticized me. I continued using the strategies of validating her perspective, clarifying my own, and asking for her help in resolving the situation as a team. It took many sessions but we were able to "agree to disagree"; she asked a different medical provider to sign the paperwork instead.

30. After vocalizing intense suicidality and an inability to stay safe, mandating the client go to the ER for an evaluation. The client felt judged and worried i would no longer work with her. She was able to use a lot of skills to avoid being admitted and was able to tell me how she felt. I was able to validate skills, still express my concern and that her behaviors had consequences. Afterwards she used phone coaching less for a week or so to avoid "worrying" me but was able to see that nothing had changed in our relationship and I wanted to keep working with her and that unlike in the past with family and other therapists, she was not too much for me. I am more aware of my emotion mind worry when she expresses her feelings of suicidality and we are working separating out ideation and intent more effectively. I also was able to reiterate the goal if "putting suicide on the shelf" as a solution to her problems and pain. This allowed us to go back to the basics because our drift into some trauma work was too triggering at this time. Overall, I think this was an important experience did us to go through so she could understand that I keep me word and my working with her is not contingent in her just pleasing me.

31. Since I treat individuals with BPD using DBT, this type of therapy interfering behavior occurs frequently. I often observe a subtle behavior (facial shift, tonal quality, or comment made) and observe it. Often clients who have been with me for a while, or are familiar with my 'in the moment observations and assessments, will take a minute and notice whatever it is that they were thinking, feeling, or wondering about. I follow up with a thorough chain analysis where I have the client observe the event that prompted them, noticing their thoughts or interpretations, the emotions that they feel, and how it is that they want to proceed with it. I remind them that they have the freedom to choose how they want to proceed with their experience, be it check the facts with me regarding their concerns/thoughts, or using emotion regulation/distress tolerance skills, or even just to be mindful of it. Sometimes I need to remind them of a pattern or experiencing the world in 'that' way, and others, I need to validate their point of view and see the kernel of truth in their experience. This usually strengthens the relationship.

32. When a rupture occurred with an individual due to a misunderstanding of expectation to attend individual and group therapy, a repair (apology - we are all human and make mistakes) was made at earliest opportunity to resolve rupture.

33. I refer to the 'rupture' as "lack of progress"; I use a systematic process to ID & assess '-'lack of progress'-sources. The process I use explores 8 different domains that tend to help the client and I, collaboratively, ID which domain(s) contribute to the 'lack of progress'. Of the 8 domains, those I tend to find responsible are 1-Low readiness to change, 2-Un-shared treatment goals, 3-Treatment plan that is not being fully implemented. I am a DBT-Linehan Certified therapist, therefore the therapeutic alliance is critical for ongoing progress as part of the treatment itself. Ex: After 19 months of stage 1 DBT treatment with a 24 yr old female client, following successful elimination of suicidal behaviors, she continued intermittent self-harm bx's which at 19 months, started to increase in frequency; the client

demonstrated an increase in resistance to using certain skills required for self-harm elimination; her outcome measures also began indicating a plateau in progress and most importantly, she began entering into sessions w/ an angry affect & body language, lots of silence and undertones of sarcasm in reference to the most DBT skills, cognitive restructuring attempts and refused exposure exercises while insisting "I have done all this and it clearly doesnt work". After large doses of validation of her obvious frustration with her emotional pain that just wasn't remitting, and agreeing with her frustration regarding her apparent lack of progress, I initiated a 'heart to heart' conversation with her to remove the obvious elephant in the room, disclosed my own personal/emotional experience of working w/ her weekly and encouraged a dialogue of the potential 8 problem areas (domains) that could be contributing to the problem. Client's initial reaction was relief, We used the 'Lack of Progress' worksheet and discovered the primary problem was "low readiness to change". The client admitted after much validation and compassionate responses from me, that deep down, she really did believe that her simple attendance each week "would somehow make me better; I dont actually want to change the way I think or my beliefs even though I know they're hurting me, it terrifies me to let go of them". Our decision was to put her on a 3 week DBT-therapy vacation, for the purpose of giving her the freedom to chose, and give her time to think about what she is and is not willing to do in order to make changes in her life, in order to reach her life-worth-living goals. She came back 3 weeks later-ready to work. That was a year ago and now, she's graduating w her MA and in a solid, healthy relationship (exposure!) and using, although reluctantly, the deeper skills that are required for true, inner, change. No self-harm in one year, she's in stage 3 DBT and working on shame resilience and self compassion. Without that heart to heart and Identification of the lack of progress, w/ solutions as well, I doubt she would have made it this far and would likely still be in/out of hospitals, or worse. I cannot speak enough to the importance of this topic! (**removed personal identifying information to protect the anonymity of the respondent*).

34. When meeting a new client and doing intake assessment I have very occasionally found that when I ask how they feel I (or the service) could help them the response has been and angry - "what is wrong with you, don't you know how you can help me - you are supposed to be the expert, i am here because I don't know what to do - you should know how to help me not be asking me". Also with another woman when I explained to her at intake we had moved her up the waiting list so she could be seen sooner as her nurse was concerned about her - my intention with this comment was to validate her and make her feel she was important and that how she was feeling was important to us - at the time she accepted this statement but when she returned following week told me she had thought more about it and had concluded I did not want to see her but had been forced to do so by her nurse, and that I did not like her and any attempt on my part to change this perception was futile. In both situations all I felt I could do was apologise for causing them distress, try to clarify what I had meant, and try to explore how to repair things. When I know clients well and have been seeing them for a while Such situations are much less likely to arise - I try to ensure at an early stage all my clients know it is safe for them to tell me I have misunderstood what they have said, I am talking rubbish, my hypothesis is wrong etc and that I will be grateful not upset, as I do get things wrong and want to understand them better more accurately etc. This reduces possibility of severe ruptures if clients feel safe to raise things as soon as I make an error, rather than dwell on them.

35. I judged my client in session and found out from my team she reported being offended in skills group. I called to make a repair. I didn't get a hold of her via phone so waited until session to tell her I realized my misstep. Her group homework was to develop a FAST so we used my judging her as an example. She called me two days later to tell me her true emotions were anger. I called to thank her as a reinforcement for her calling and communicating so clearly her emotions, a huge mastery for her.

36. I said something triggering to a client who frequently disassociates and she disassociated immediately. I acknowledged that she had gone away and she confirmed she had. I let her know the trigger seemed to be something I said. I asked her if she was feeling unsafe and if she would talk to me about it. We discovered that what I said challenged part of a belief system she's adapted that represents a feeling of safely in the world. We then talked about my beliefs on the subject and how they were different than what she had interpreted. She was able to see that, affirmed she felt safe again, and said the experience was very helpful to her.

37. Last week a client became angry when, during the assessment, I asked him about alcohol use. When I tried to have him be more specific in his answer in order to get an idea of how much he drinks presently, he seemed to become triggered. I explained the rationale for the question - part of the assessment, I'm not making an assumption about his alcohol use but ask everyone these questions, the connection between mental health problems and substances, etc. - his anger wasn't assuaged. As I attempted to continue to move forward, his anger remained; and so I expressed to him my confusion about where the anger was coming from. I emphasized the importance of the two of us being able to work together if I'm to help him with his depression, and the importance therefore of us having a good working relationship/therapeutic rapport. I emphasized that I wanted to understand where his anger was coming from so that we could work on this and move forward productively. I also expressed that I was feeling defensive because of the anger that felt directed toward me. He was then able to share some information about his past that was contributing to his frustration, and we were able to resolve this and move on (for which I validated him)

38. One client continued to "forget" to bring in Diary Cards and group homework for review and discussion. This client would also want to avoid discussion of how to use skills to cope with stressors and mental health issues. Brought the situation to awareness, examined if there were times with other people in which the client would not bring necessary items to the table, and how to create willingness to learn how to do what is needed for therapy to work. Client was willing to discuss and offered a compromise that worked for both of us, and her compliance was increased and sessions were better.

39. I recently pushed too hard for change with a client who was very depressed and suicidal. After the session I was able to see that I had pushed too hard for change. I was able to acknowledge this to the client and validate how this must have felt. We were then able to repair the rupture to the relationship together and move forward with a plan for future sessions and much clearer communication and deeper connection.

40. Hi Jessica, I changed a client's diagnosis to OCPD and client was upset that I gave her this diagnosis when "I thought I was getting better and doing well. Now you tell me I am sicker. You crushed my world." I validated feelings, id'd rupture marker, and used 5 step rupture repair process. Id'd my part in this. Shared how this impacted me and redeveloped treatment plan with new diagnosis and goals. We look back on this now as a real pivotal moment in her treatment. She is thankful now however still has shame triggered at times.

41. Client was avoiding a new treatment plan due to fear. Client questioned clinician's goal in new treatment plan. We identified fear, reestablished client's goal and did fact checking on client's perceived judgments coming from clinician.

42. One of my clients has done a lot of difficult work to learn to observe, identify, and express her

emotions. As she has grown in this capacity, she has also become more deeply touched by her sadness, shame, and feeling alone. A few weeks ago, she interpreted this change as a setback and shared with me her view of my response to her increased emotional experiencing as "cold-hearted and uncaring." Her anger about her progress in therapy then played a role in her arriving late to the next therapy session (this was discovered through chain analysis as we have been targeting late arrivals). Through talking with members of my consultation team, I realized I needed to reorient the client, and explain to her that her increased misery is a sign that she is more in touch with her emotions. I shared this with the client and provided a lot of validation and we discussed how we plan to move forward. I believe the rupture is now resolved as the client and I have come to the conclusion that it would be effective to start processing trauma, which is what is underlying the client's intense feelings of sadness. The challenge for me, which is shown through this situation, is calibrating my balance of acceptance and change to where the client is on a given day and also in context of their overall progress in treatment.

43. I had been seeing a male client for supportive counseling and case mgmt. for several years when he got into legal trouble and had a probation officer. The probation officer wanted a thorough substance use assessment and I already knew the extent of the client's use of substances over time. The requirement to report honestly created a rupture in the therapeutic alliance. This was overtly acknowledged/recognized by both client and me. It was repaired over time, primarily by this therapist's consistency with the client and directness about what information had to be shared. Honesty and direct communication seemed most effective in the repair.

44. I linked a therapy-interfering behaviour I observed in-session to relationship difficulties my client was having. She became tearful and did not want to come back for further sessions. By discussing the dialectic and observing my own fallibility and validating the pain she experienced, we were able to resolve this rupture.

45. Recently in couples therapy when trying to explore a client's thoughts and feelings about a family matter she thought the purpose of my questions was to point out that her husband's point of view was more valid. I was able to explain that I was interested in her thoughts and feelings and her goals for the situation they were dealing with . She was able to hear this and express her thoughts and feelings without fear of being blamed or rejected.

46. One situation that comes to mind occurred when I became frustrated during a session due to what I perceived as lack of collaboration. In other words, it felt like we were working on different goals. I observed my perception that we were not collaborating, asked whether the client was perceiving it the same way, and she actually was not perceiving it that way. What was occurring was that she was having strong emotion that she was not expressing. Taking the step back, and making the observation about what seemed to be happening in session, allowed us to have a dialogue about what was occurring in the moment. Then we could problem solve it in order to resolve the rupture.

47. Client became upset and angry with me when she did not experience warmth and support from me during a panic attack in session, and how later I did not spent enough time with her during a shorter, more administrative interaction. Rupture was apparent as client make it verbally clear to me that she was angry with me, and made complaints about me to the manager, etc. We repaired and resolved this rupture by revisiting and discussing what happened during the interaction. Client eventually felt validated when I acknowledged that her perception of me rushing through the administrative intention was, in fact, correct, as I was very short on time. This experienced opened up the way for us to discuss how client's current emotional and behavioral difficulties are related to the way she was dismissed,

ignored, punished growing up.

48. I charged a client for a session he forgot about over a holiday. When schedule disruptions or vacations came up after that he got wary and guarded. I asked him about that and he was angry and then admitted he was hurt. I clarified our possible miscommunication and that he might have felt punished or shamed which he did. We made a plan to communicate carefully re changes in schedules.

49. I am being trained by a Linehan DBT certified clinician, who's taught me how to assess for the 'ruptures' and how to create solutions with the clients. I am still learning this technique but in all my years of training and supervision as a therapist, this is the 1st time I've ever been able to really learn "what to do". I have many clients who are resistant to my clinical interventions and ideas; and I find that I do get angry and want to avoid them. But with this help from my supervisor who is training me in this area I can now know what to do and how to have conversations with my few clients I do serve, and teach them that this is not abnormal as my supervisor puts it, and then work together or "collaboratively" as I'm now aware, in order to restore the aim of therapy and get back onto the goal work we've been trying to do. There's a form I use now to get assessment details about the potential problems causing the rupture, and then the client gets to take it home for homework and see if that helps figure out the problem then we work the next session together on finding both our ways back to the relationship, which takes work. and it's worth it. The training, from what I know in over 35 years of doing therapy is the 1st I've ever heard of. My DBT certified supervisor has helped me learn the importance of understanding the ruptures, why they happen and that they are normal. I always thought it was my fault and now I know that it's okay and that I can move through with clients and find ways around this. I find now that when I used to lose clients to "i dont know why", that doesnt happen anymore. people tend to come back now, since we are able to be that open about the ruptures and make it like it's no one's fault, just work on solving it.

50. I saw a client who was complaining about her husband and his porn addiction and I encouraged her to look more at herself and where else could she get her non-sexual needs met. She didn't like to think about herself as a non-victim. I went back to where she was at, and waited until she could think about owning her unhappiness and finding ways she could get other emotional/social needs met that didn't include her husband. Used her muslim-faith basis to aid her in her resolve not to seek sexual satisfaction outside of her marriage at this point. Had 4 sons at home and she did not have an income that would support herself and her boys.

51. I run a domestic abuse group and I have men who need to complete a series of tasks before they can complete the program. Many men avoid talking to me about when they expect to graduate from the program and when graduation is later than they expect, they get upset with me. To address this I usually try and pay attention to the number of sessions a client has completed and as we get close to the number of sessions needed to complete, I mention what tasks are still not completed. I validate their concern about not finishing on time and that 'we will do our best' to have the person graduate as soon as they can.

52. One of my individuals continually challenged my abilities as a therapist, often questioning if I knew what I was doing. I had been seeing this individual for over a year and she still returned every week for her appointment. I was feeling frustrated and ready to transfer her to someone else. In spoke with my clinical supervisor about the situation and we discussed the relationship that had been established between the individual and myself. I met with the individual, explained my thoughts on how her comments and attacks affected our relationship. We discussed her expectations of me and how this

might be a pattern for her in keeping people at a distant. I offered to transfer her to another therapist, if that is what she wanted. I explained I was willing to continue to work with her; however, I would not be subjected to further verbal attacks. This individual decided to remain in treatment with me and our relationship has really grown therapeutically.

53. When a client expressed that the manner in which I spoke something was more direct then they were comfortable with we were able to discuss this. I realize now that this client needs a less direct approach and I work to speak more gently with her. Whether this is a general feeling with her and "her issue" does not matter. If i want to connect and keep the alliance with client then I must be willing to change my approach. This is not easy for me. My first inclination is pretty direct. I believe this was resolved through my working to really think about how I will say what I am going to say to client.

54. Recently a client said, "whoa, it's getting conflicting in here," after I attempted to challenge her to make changes in her behavior related to exposing herself to her fear. I told her that it's ok for us to disagree and acknowledged her feelings and apologized for making her feel like I was against her. I restated my goal to help her change her behavior and not to do encourage her to do anything that she did not feel comfortable doing as she stated that others therapists had done in the past.

55. I had a client who was diagnosed with GAD (Generalized Anxiety Disorder) who wasn't responding to my phone messages 5 days later after she was trying to get a hold of me. I wasn't able to contact her during this time due to my Mother tragically passing away. When I did finally contact her, she learned of my personal loss and originally had been very mad at me but quickly became very embarrassed when she learned of my loss. To this day, she is more forgiving and understanding; in the past she would have attributed this to abandonment she had experienced in the past.

56. My client was a woman in her early 50's who I worked with for several years to help her with symptoms of inability to leave her depression, mood swings, early childhood trauma. She became much better but still needed treatment for awhile to maintain her progress. Inexplicably she began cancelling appointments without explanation or revealing little about her feelings in sessions. She eventually told me she was uncomfortable because she felt sexual feelings toward me or else "inappropriately" emotionally attached to me. What helped us through this impasse was my ability to sit with ambiguity not knowing what was happening for several weeks. When she courageously revealed her anxiety about her feelings I used reflective listening to understand and normalize. With consultation from a colleague she learned such feelings are normal and she need not fear feeling close to me.

57. A client at first refused to see me after I came back from a 3-month maternity leave. She requested a transfer, so I called her. After speaking with her on the phone, and telling her the interim therapist had no availability to see her (which was true), she agreed to see me. During our session, the client shared her feelings of frustration and abandonment about my maternity leave, and her guilt around having those feelings. It also allowed her to open up about the trauma she went through during the birth of her son (they both almost died) and a late-term miscarriage. She has been very engaged in treatment every since that session nearly two years ago.

58. Clients insurance changed and I thought she would need to be referred elsewhere. She interpretated this as abandonment and was angry that I hadn't discussed other options. We discussed both my assumptions and her interpretations and were able to work through this rupture. We also looked at how she often interprets of others actions a abandonment when it might not be.

59. A client (adolescent male) took my phone from my desk as I was in rounds. The clinical team had enough evidence to point to him, in part because his history included repeated acts of theft and in part because of other evidence. It was important to see the opportunity presented in this occasion and to avoid judgment and shame - this is what Pt was here to treat, after all. And I could see how it would be hard for me to continue working with him after trust had been broken in such a way, as well as for Pt to work with me with such a heavy secret and/or the shame of his action. I started our meeting by apologizing to him for my part in this: having left my phone on my desk, with an unlocked door, while knowing his history. I compared it to leaving a blade in evidence with a self-harming client. I clarified how understandable, although not acceptable, his action had been. And we together re-grouped around his treatment objective (to avoid jail.) This gave him the energy and commitment to analyze with me with great curiosity his behaviors, thoughts, urges and to decide on a different course of action for next time he finds himself in this situation. It also gave him a chance to repair our relationship with a heartfelt apology and for me to hear (and point out to him) his desire to continue to improve going forward.
60. DBT client skillfully describes feeling as if therapist doesn't really care, and doesn't push client hard enough. Respond non-defensively, validating the concern, and reviewing pros and cons of options for moving forward. Treat the relationship as a real relationship between equals, the therapist is fallible, and assuming that repairing relationships is a valuable skill that the therapy relationship can be useful to practice on.
61. Resident was upset I was open and honest with her probation officer regarding her progress in treatment and ongoing willful behavior. As a result, this resulted in her length of stay being extended and a stern lecture from her probation officer. I validated her frustration toward me, however, I also expressed to her that she is here for treatment and reminded her of her commitment to wanting to make positive changes for herself and of the small steps she had made to date in treatment.

Statistic	Value
Total Responses	61

26. I am a:

#	Answer		Response	%
1	Male		7	10%
2	Female		62	90%
3	Other		0	0%
	Total		69	100%

Other

Statistic	Value
Min Value	1
Max Value	2
Mean	1.90
Variance	0.09
Standard Deviation	0.30
Total Responses	69

27. I am (age):

#	Answer		Response	%
1	< 25		0	0%
2	26 - 30		4	6%
3	31 - 35		14	20%
4	36 - 40		7	10%
5	41 - 45		10	14%
6	46 - 50		11	16%
7	51 - 55		7	10%
8	56 - 60		9	13%
9	> 60		8	11%
	Total		70	100%

Statistic	Value
Min Value	2
Max Value	9
Mean	5.53
Variance	4.75
Standard Deviation	2.18
Total Responses	70

28. The highest degree I have received is:

#	Answer		Response	%
1	Bachelors		0	0%
2	Masters		53	76%
3	Doctorate		15	21%
4	Other		2	3%
	Total		70	100%

Other
Postgraduate Diploma in Clinical Psychology
Post Graduate Diploma in clinical Psychology

Statistic	Value
Min Value	2
Max Value	4
Mean	2.27
Variance	0.26
Standard Deviation	0.51
Total Responses	70

29. I have been a mental health practitioner for:

#	Answer		Response	%
1	2 - 5 Years		12	17%
2	6 - 10 Years		13	19%
3	11 - 15 Years		14	20%
4	16- 20 Years		8	11%
5	20 + Years		23	33%
	Total		70	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.24
Variance	2.27
Standard Deviation	1.51
Total Responses	70

30. I am Licensed as a: Please check all that apply.

#	Answer		Response	%
1	LSW		2	3%
2	LGSW		3	4%
3	LISW		1	1%
4	LICSW		22	31%
5	LP		6	9%
6	LMFT		3	4%
7	LPC		4	6%
8	LPCC		4	6%
9	LIDC		0	0%
10	Tribal Mental Health Practitioner		0	0%
11	Other:		28	40%
12	None		2	3%

Other:
clinical psychologist
LCSW in the state of Colorado (equavilent to LICSW)
LCSW-BACS
LAPC (Licensed Associate Professional Counselor)
LMHC
Nurse Practitioner,
LCSW
LMSW (this is the credential in New York State where I am employed)
LMHC Licensed Mental Health Professional
Registered Psychotherapist (in Ontario Canada)
LMHC
Psychologist (PhD)
Registered Clinical Psychologist (New Zealand)
LCSW
Clinical Psychologist
Clinical psychologist
Psy.D.
psychologist
LMHC
Clinical Psychologist in New Zealand
Canadian - MSW, RSW
Clinical Psychologist
Psychologist
LCSW in NJ. Not sure how it translates into the abbreviations above.
PhD
Addictions Counselor
PhD. Psychologist
LCSW

Statistic	Value
Min Value	1
Max Value	12
Total Responses	70

31. What treatment modalities do you utilize in your practice? Please check all that apply:

#	Answer		Response	%
1	Dialectical Behavioral Therapy (DBT)		52	76%
2	Cognitive Behavioral Therapy (CBT)		57	84%
3	Psychoanalysis		10	15%
4	Play Therapy		9	13%
5	Narrative Therapy		11	16%
6	Solution-Focused Therapy		26	38%
7	Exposure Therapy		25	37%
8	Other:		23	34%

Other:
Motivational Enhancement Therapy
Psycodynamically oriented psycotherapy
Psychoeducation; Elements of DBT, CBT, and narrative therapy but due to the setting (inpatient psychiatric unit), clients are involved for an average of 3-7 days so full or even short-term CBT and DBT are not possible
Psychodynamic Therapy, behavioral, EMDR, Strength focused therapy, Feminist family therapy, Existential therapy, Supportive therapy
EMDR, Acceptance & Commitment Therapy
Psychodynamic
EMDR, Acceptance & Commitment Therapy
Psychodynamic psychotherapy
EMDR, TFT, Psycho-education
Psychodynamic psychotherapy
Functional Analytic Psychotherapy (FAP), Emotion-Focused Therapy (EFT), REBT Certified
supportive counselling, mindfulness based therapy for depression and anxiety
Attachment theory
Psychodynamic; Motivational Interviewing
Marriage and Family therapy.
Ego Psychology
MBCBT
christian faith-based strategies, temperament counseling.
Motivational Interviewing
Trauma Focused CBT
Psychodynamic and Relational Psychotherapy
EMDR
Psychodynamic, family systems

Statistic	Value
Min Value	1
Max Value	8
Total Responses	68

Appendix D. QUALITATIVE THEMED CODING

	RECOGNIZE	REPAIR	RESOLVE
1.	Over-pacing the client	Naming the rupture	Therapist taking responsibility for rupture
2.	Client disengagement	Acknowledging feelings of progress as exciting and overwhelming	Worked collaboratively and identified vulnerability factors to reestablish therapeutic goal
3.	Displayed by being late to session	Therapist acknowledged their own feelings of excitement for progress instead of staying with client	Therapist helped client understand that therapists feelings were from a place of caring and being vested in helping her reach her goals
4.	Displayed by not showing for session	Named reason for disappointment/rupture	Assisting the client to learn ways to repair the relationship when there has been a rupture (new relational experience)
5.	Patient noticed disappointment in therapist's demeanor	Therapist identified and defined rupture/misperception as concern, disappointment, safety of others, and rupture in trust	Made correlation with client that when topics become overwhelming, client would previously run away
6.	Client felt it was unfair for therapist/staff to feel disappointed	Discussion about options on how to express anger	Developed a plan for limiting time spent on certain topics
7.	Client cancelled session	Therapist processed post-session and determined the client was resistant to pushing for change during intake	Discussed strategies for client to proactively identify when subject becomes too painful instead of shutting down
8.	Client didn't like the use of the phrase "It's up to you."	Emphasized client validation, came back to where the client was (didn't push so hard for change)	Identified associated feelings of invalidation by comment and reframed question as it aligned with treatment goal
9.	"I rarely have experienced a rupture that is not repairable."	Therapist provided client with an activity to assist with discussing difficult subject matters (coloring)	Problem solve with client to ensure it didn't happen again
10.	Client seemed distant, defensive, with flat affect.	Explored with client the structure of the session, was it too painful, ineffective, overwhelming?	Client appreciated honesty and was able to have a good relationship thereafter
11.	Client began limiting responses in session	Therapist explained meaning behind comment, addressed	Identified alternative coping mechanism to sit in the

	RECOGNIZE	REPAIR	RESOLVE
		clients assumption about meaning	waiting room when needed
12.	Therapist made an offhand comment, client brought it up in next session saying it upset her	Began next session by acknowledging what happened and asked what client thought happened	Client would raise left hand when a breach occurred in session
13.	Client was angry, sarcastic, and ended session early	Therapist realized that supervision should have been used to address transference issues	Linked occurrence in session to events in the patient's life
14.	Client was difficult to engage, cancelled appointments, no showed	Addressed in session therapist's reason in demeanor (own loss of pet)	"The rupture/repair was an essential part of the healing process with this client."
15.	Therapist recognized transference issues that impacted the relationship (loss of pet against clients own loss, frustrations with cancellations)	Arrangements were made for client to see another provider in therapist's absence	Give client space to process as they feel comfortable
16.	Therapist felt tension in session, therapist was not empathetic, patient, or validating	Exploration of what occurred to cause the breach in session	Meeting clients needs and allowing them time to become grounded to have a joint conversation about the situation
17.	Client appeared closed and hurt in her body language, made false promises to come back	Client's feelings of being betrayed and forcing them to remain hospitalized, therapist is no longer a trusted advocate on their behalf	Client requested therapist join in game play as they have played together previously
18.	Client complained to therapist's supervisor	Therapist inquired about the client's game play and if it was to avoid addressing painful issues	Therapist changed therapy goals and came back to where the client was ready to work on change on a macro level while associating it to grief/loss issues (abandonment)
19.	Therapist had to suspend practice, informed clients in person and by letter	Therapist validated client and listened to clients point of view	Client connected in-session behavior with a refusal to accept reality of the mother he received as a child
20.	Client was visually distressed	Therapist shared reason from blocking her from interrupting her mother	Client had better awareness and learned how to make new life decisions
21.	Clients are reactant and express not wanting to be	Spoke to client and client identified not ready to work	Therapist offered compassion and took ownership for

	RECOGNIZE	REPAIR	RESOLVE
	hospitalized	on grief/loss right now	therapist's impact on relationship
22.	Impact of symptoms (psychosis) on therapeutic process – decrease in orientation, disengagement, and commitment	Therapist became aware of the common rupture pattern	Assisted the client to find new ways to cope with disappointments in therapeutic relationship and other relationships
23.	Giving clients bad news (having to remain hospitalized)	Addressed ruptures in session	Contracted with client to check in at the end of each session
24.	Client focused on cell phone, playing a game, and ignored the therapist	Identifying clients personal relationship felt they were being "therapized" when client was attempting to be skillful and asking clarifying questions	Therapist commenced each session with the status of the therapeutic relationship
25.	Client stated she felt invalidated by therapist blocking her from interrupting her mother's comments	Therapist allowed client to vent and therapist asked questions about the rupture	Therapist changed therapeutic intervention and designed homework to what client felt comfortable working on
26.	Therapist recognized client was angry	Therapist made connections between the therapeutic relationship and client's friends and family	Therapist apologized and committed to changing focus on maintenance rather than change
27.	Client became compliant even though they did not want to continue with specific intervention	Addressed client's misperception of therapist that they would be like others who ignore her concerns and continue to push for what they wanted in therapy	Therapist encouraged client to inform therapist to "reel her in" when she got too far ahead
28.	Client began avoiding therapist in facility and missing appointments	Therapist acknowledged with client that she should have recognized and respected her subtle signs of "enough"	Client felt more in control of her therapy and promoted a safe environment and collaborative relationship
29.	Client would pick fights with the therapist	Therapist realized they had not properly oriented client to DBT	Therapist linked the rupture in alliance to similar events in clients life and lead to a new relational experience
30.	Client would question if the therapist was the "right therapist for them."	Therapist explained to client that they have a tendency of getting ahead of themselves due to enthusiasm of getting started	Client was put on vacation and reminded of expectations for when she returned
31.	Client verbalized	Therapist re-explained	Client realized that she gets

	RECOGNIZE	REPAIR	RESOLVE
	disappointment in therapist's inattentiveness and commitment	therapeutic intervention and expectation of client in session	triggered when hearing the "vacation"
32.	Clients support system did not support the client in getting therapy	Addressed clients feelings of anger and hurt and how the therapist could "do this to her"	Therapist reiterated treatment strategy and explanation of intervention
33.	Client became angry with therapist and felt therapist was trying to ruin her relationships with homework	Validated clients anger	Therapist ensured time was spent reviewing clients diary card in its entirety
34.	Client attacked therapist for the type of therapy and approaches used	Therapist addressed clients feelings that therapist didn't care what was on the diary card	Therapist explained reason for taking clients weight and helped client understand its importance
35.	Therapist's realization of pushing too hard for change	Client became aware she was afraid she would resort to obsessively weighing herself again because the therapist had weighed her during their last session	Therapist engaged in team treatment planning sessions and increased peer supervision
36.	Client became enraged	Validated distress	Client accepted a handover plan for when the therapist was on maternity leave
37.	Client was not bringing diary card after it was addressed and chained in session	Was open and honest with client	Made correlation between behavior of therapist and client's mother in childhood.
38.	Client was very upset and compliant with completing diary card	Encourage skillful behavior	Therapist acknowledged and validated client and addressed misperceptions of comment made by therapist
39.	Client became angry	Addressed clients high expectations for therapist	Explored therapeutic options and emphasized clients power and control in situation.
40.	Client became angry with CPS and Therapist	Exploration of what came up for client during comment	Therapist allowed client to choose activity for next session.
41.	Client became highly suicidal	Therapist explained where they were coming from and what they meant by the comment	Increased awareness in therapist looking for themes of disappointment
42.	Client blamed therapist for not doing the 'correct therapy'	Therapist validated clients anger and pain and explored feelings with client	Agreed upon a set of guidelines for the future to prevent the situation from

	RECOGNIZE	REPAIR	RESOLVE
			occurring again
43.	Therapist informed client of impending maternity leave and client was triggered with fears of abandonment	Therapist inquired about reasons why client wanted to leave	Client agreed to bring it up in session if it happened again
44.	Client was angry	Client acknowledged their concern for feeling that the therapist was disappointed in them	Client became aware that she experiences difficulty in understanding others' communications
48.	Client became defensive	Therapist explained they were not disappointed and considered their impact on the client	Therapist encouraged client to stop therapist when communication becomes overwhelming or confusing
46.	Client yelled and stated they didn't want to come here anymore, said its boring	Exploration of feelings and interpretations of rupture event	Increased clients control within relationship
47.	Client wanted to end treatment and made superficial excuses regarding the reason	Explored intentions of therapist	Therapist asked client for help in resolving situation as a team (collaborative)
48.	Client stated therapist brought a situation from individual therapy into group and she felt a betrayal of trust	Group members confronted leaders and were encouraged to discuss their feelings	New relational experience
49.	Comments by co-facilitators were misunderstood by group members who were already unhappy with the dynamics and discussions	Leaders listened non-defensively and gave everyone the opportunity to say how they felt reflecting back what they were saying	Therapist did not treat client like family and friends had when she became 'too much'
50.	Client became difficult and defiant	Therapist attended to distress of client and inquired about parallel experiences with other relationships	Reiteration of treatment goals and went back to basics acknowledging client discomfort in moving too fast into trauma work
51.	Client became distressed and tearful and yelled at therapist for expecting too much from her	Therapist validated clients perspective and clarified therapists perspective	Remind client they have the freedom to choose how they want to proceed
52.	Client became angry and criticized therapist after not hearing what she wanted to hear	Client was able to use her skills and share how she felt	Utilized lack of progress worksheet and realized clients low readiness for change
53.	Client experienced intense suicidality and inability to stay safe	Therapist validated skills and expressed concern for sending client to ER	Put client on vacation to think about what she is and is not willing to change

	RECOGNIZE	REPAIR	RESOLVE
54.	Client felt judged and worried therapist would no longer work with her	Chain analysis of client evaluating what they were thinking/feeling	Gave client freedom and power to choose
55.	Subtle behavior like facial shift, tonal quality, or comment made and observe it	Check the facts	Encourage client to speak up when they have misunderstood
56.	Understanding when a misunderstanding has occurred	Apology, acknowledgement of the behavior	Increase clients sense of safety in therapy
57.	Lack of progress	Validation	Therapist disclosed own feelings of event
58.	Low readiness to change	Addressed the elephant in the room	Client offered a compromise
59.	Unshared treatment goals	Therapist disclosed their own experience	Clearer communication
60.	Treatment plan not being fully implemented	Apologize, take ownership of the situation	Deeper connection
61.	Increase in self-harm behaviors	Attempted to call client to acknowledge therapist misstep	Redeveloped treatment plan with new diagnosis and goals
62.	Increase in resistance to using skills	Used skillful behavior to address rupture	Reestablished clients goal
63.	Poor outcome measures	Client contacted therapist after realizing what her true emotions were	Received consultation
64.	Clients affect was angry	Therapist validated client	Therapist reorienting themselves and calibrating balance of acceptance and change to where the client is
65.	Observing clients body language	Use of positive reinforcement	Therapists overt expression of what had been shared
66.	Use of silence	Acknowledged rupture, discussed it	Open communication
67.	Undertones of sarcasm	Therapist disclosed their beliefs and client realized they were different then how they interpreted them	Client was provided space to share concerns without fear of being blamed or rejected
68.	Refusal of treatment activities	Therapist explained rationale for the question	Creating an open dialogue
69.	Anger, ‘what is wrong with you, don’t you know how you can help me, you’re supposed to be the expert!’	Therapist expressed the importance of maintaining a strong therapeutic bond to promote outcomes	Therapist disclosed how they experienced the rupture event
70.	Client addressed misinterpretation of therapist	Therapist disclosed own feelings of event	Addressed similarities between clients current

	RECOGNIZE	REPAIR	RESOLVE
	comment		emotional and behavioral difficulties are related to the way she was dismissed, ignored, and punished growing up
71.	Client informed team she felt offended in skills group	Validation for client	Create a plan to communicate more carefully the changes in schedule
72.	Therapist realized they said something triggering and client dissociated	Brought the situation to awareness	Encourage client to work collaboratively
73.	Client became angry	Examined if there was a parallel process with therapist and personal relationships	Restore the aim of therapy and get back on track with treatment goals
74.	Client became triggered	Therapist acknowledged with client their desire to push for change	Using a form/scale to get assessment details about potential problems
75.	'Forgetting' to bring diary card and group homework	Validation of feelings	Went back to where the client was
76.	Avoidance of discussion of how to use skills to cope	Used 5-step repair process	Therapist assisted client to determine difference avenues in which to help her problem solve her situation
77.	Therapist pushed too hard for change and realized that	Identified fear	Therapist would be more mindful of progress and success made by client.
78.	Client was upset that their diagnosis had changed when they through they were making progress and getting better	Checked the facts on clients perceived judgments	Working with client to achieve goals
79.	Client avoidant to new treatment plan due to fear	Reorient the client	Therapist recognized own feelings of frustration when client wanted to transfer to another provider
80.	Client questioned therapists goal in treatment plan	Validation for the client	Therapist offered to transfer client to another therapist
81.	Client interpreted her success as a setback and found her therapists response cold-hearted and uncaring	Acknowledge a rupture has occurred	Set limits
82.	Client anger	Discussed the dialectic and observed therapists own fallibility and validated client	Therapist acknowledged clients concern and agreed to take a less direct approach

	RECOGNIZE	REPAIR	RESOLVE
		pain	when speaking to her
83.	Client arriving late to session	Therapist expressed interest in clients thoughts and feelings and goals	Therapist was willing to change approach with client
84.	Therapist having to provide probation office with updates regarding the clients substance use	Therapist shared their perception and asked client if they felt the same way	Therapist laid precedent that it's okay to disagree
85.	Therapy-interfering behavior	Problem solving with client	Therapist restated goal and gave client control to move at her pace
86.	Client was tearful	Discussed the rupture event	Client was able to identify misperception in how the therapist was responding to them
87.	Client didn't want to return for future sessions	Validated client	Therapist used consultation
88.	Client misinterpreted therapists line of questioning and felt invalidated that therapists thought husbands view was more valid	Therapist inquired about clients behavior	Therapist apologized for their part of the rupture
89.	Therapist identified feeling frustrated during a session due to a perceived lack of collaboration	Client addressed the feelings they were experiencing	Client and therapist regrouped on treatment objective and decided on a different course of action for if it were to happen again
90.	Client became angry and upset and did not feel warmth and support from therapist	Validate client as not being abnormal	Review pros and cons to moving forward
91.	Client made reports to therapists supervisor	Have a conversation about the event	Treat the relationship as a real relationship between equals
92.	Client got wary and guarded	Validate concerns	Understanding that the therapist is fallible
93.	Client resistance	Therapist explained their feelings	Reviewed treatment plan
94.	Therapist gets angry and wants to avoid client	Therapist addressed clients expectations and made correlations to a pattern of keeping people at a distance in their personal life	
95.	Client disagreed with perception of problem and view of therapist	Therapist acknowledged clients concern and agreed to take	

	RECOGNIZE	REPAIR	RESOLVE
96.	Client would avoid talking to the therapist	Acknowledged clients feelings	
97.	Client got upset	Therapist apologized	
98.	Client challenged abilities of therapist	Therapist explained reason for being distant due to personal stressors	
99.	Client questioned therapist if they knew what they were doing	Therapist sat with ambiguity and used reflective listening to understand and normalize	
100.	Client expressed therapist used language that was more direct than they were comfortable with	Discussion of feelings of abandonment and frustration	
101.	Client states, 'whoa, it's getting conflicting in here'	Discussed clients assumptions and her interpretations	
102.	Client was not responding to phone messages	Therapist made connection to how client interprets others actions as abandonment when it might not be	
103.	Client was angry	Validated actions of the client	
104.	Client would cancel sessions	Client was given the opportunity to repair the rupture by apologizing	
105.	Client would reveal little about her feelings in sessions	Respond non-defensively	
106.	Client acknowledged they began to have sexual feelings towards the therapist and felt uncomfortable	Validate the concern	
107.	Client refused to see therapist after returning from maternity leave	Validated clients frustration	
108.	Client request to transfer to another therapist	Reminded client of commitment	
109.	Client felt guilty for having certain feelings		
110.	Client transference		
111.	Clients insurance changed and thought she would need to be referred elsewhere. Client interpreted this as abandonment and was angry that the therapist didn't discuss other options		
112.	Client stole therapists phone		

	RECOGNIZE	REPAIR	RESOLVE
	from their desk		
113.	Client states therapist doesn't care		
114.	Client states therapist doesn't push client hard enough		
115.	Client was upset		
116.	Client displayed willful behavior		